

CEPHRIS

Better Outcomes in Mental Health: An evaluation of the IDGP Programme

Centre for Equity and Primary
Health Research in Illawarra and
Shoalhaven

Lesley Hare
Karen Larsen
David Perkins

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Centre for Equity and Primary Health Research in the Illawarra and Shoalhaven
PO Box 2087
Wollongong DC
NSW
2500

david.perkins@unsw.edu.au
l.hare@unsw.edu.au

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The Centres for Primary Health Care and Equity
School of Public Health and Community Medicine
The University of New South Wales
UNSW SYDNEY NSW 2052

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Forward

This report is the completed evaluation of the Access to Allied Health Services Program **Primary Partnerships** run by the Illawarra Division of General Practice (IDGP). It expands on the interim report of December 2004 and includes the final analysis of both quantitative and qualitative data.

Acknowledgements

We would like to acknowledge the assistance of the following people and groups in the conduct of this evaluation:

Participating patients, GPs and psychologists

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Executive summary

Background

The Illawarra Division of General Practice (IDGP) Access to Allied Health Services project is one of 102 projects funded nationally. The Division developed a service model in which psychological services were provided by employed clinical psychologists supplemented by students drawn from the Clinical Psychology Masters Programme at the University of Wollongong. A key strategy of the Division is to develop new and integrated models of General Practice and Primary Care based on cooperation and partnership between appropriate professionals. IDGP contracted the Centre for Equity and Primary Health Research in the Illawarra and Shoalhaven (CEPHRIS), University of New South Wales to conduct the evaluation of its *Primary Partnerships* project.

Method

The evaluation was based on multiple sources of data and used qualitative and quantitative methods. Sources included interviews with GPs, participating psychologists and Division managers, a questionnaire to assess patient satisfaction, and de-identified activity and health status data provided by the senior psychologist. Data was analysed using NVIVO to identify key themes and Excel to assess activity and health status data.

Results

All of the GPs who were interviewed expressed satisfaction with the program. It led to better access and improved clinical outcomes for patients although there were some concerns about the associated paperwork. The clinical psychologists providing the service were strong supporters of the program and believed that the service enabled better clinical outcomes although they found the six session blocks somewhat restrictive. Their views on clinical outcomes are supported by the data from the pre- and post DASS scores. The patients who returned the questionnaires attributed improvements in their mental health status to the program despite some initial anxieties about the referrals.

Conclusion

This program has shown that the employment model can lead to clinical improvements for patients and a better and more integrated primary mental health service. It should be noted that while access has improved for some

patients, only half of the GPs registered to refer have been able to refer to date and so access is improved but only in particular localities. Some problems have arisen, such as access to clinical resources, tests and journals, as the Division is not primarily a service provider. These have been overcome through effective partnerships with local mental health services and the University of Wollongong. All parties believe that this program should be developed so as to provide access to psychological services to those who need them and cannot afford them across the region.

Background

Better Outcomes in Mental Health Care initiative

One in five of the Australian population over the age of 18 meets the criteria for a mental health problem or disorder (ADGP, 2004). Seventy five per cent of those seeking help are seen in the first instance by a GP. GPs face a number of barriers to providing quality mental health services including:

- Inadequate education and training
- Inadequate remuneration
- Limited access to allied health services
- Limited access to specialist support

Accordingly the 2001-2002 federal budget initiative Better Outcomes in Mental Health Care (BOiMHC) was introduced to address some of these barriers and thus improve the mental health care available to Australians. This four-year initiative acknowledges that many GPs are already providing primary mental health care and aims to provide financial and other supports to address the barriers to management of mental health problems and disorders in general practice (ADGP, 2004).

There are five inter-related components of the BOiMHC initiative, each of which is described in more detail in Appendix 1:

Component 1: Education and Training for GPs

Component 2: The 3 Step Mental Health Process

Component 3: Focussed Psychological Strategies

Component 4: Access to Allied Health Services

Component 5: Access to Psychiatrist Support

The Access to Allied Health Services component

This component permits eligible GPs to access focussed psychological treatment for their patients from specific allied health professionals with Divisions of General Practice (DGP) acting as fundholders. Since the initiative began, 102 Access to Allied Health Services projects have been funded in three major funding rounds (Kohn et al, 2005). The Illawarra Division of General Practice Access to Allied Health Services project **Primary Partnerships** was funded in the second round

Better Outcomes in Mental Health: An evaluation of the IDGP Programme

of national funding received after July 2003 with service delivery commencing in early 2004. The allied health professionals participating in this project are clinical psychologists directly employed by the Division.

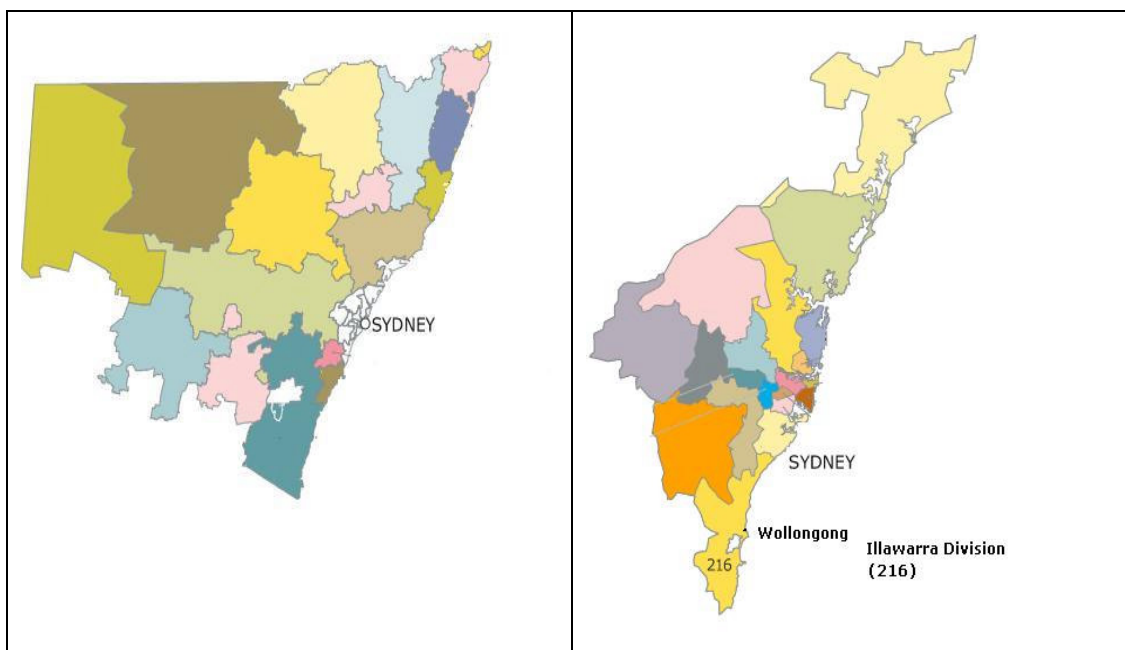
The Centre for Equity and Primary Health Research in the Illawarra and Shoalhaven (CEPHRIS), University of New South Wales was contracted to evaluate the Primary Partnerships project for Illawarra Division of General Practice. The evaluation process was delayed when the University of Wollongong/Illawarra Area Health Service Human Research Ethics Committee insisted that application be made through the University of New South Wales (UNSW). Ethics approval for the evaluation was granted by UNSW in April 2004.

Illawarra characteristics

Illawarra Division of General Practice

The Illawarra Division of General Practice (IDGP) is classified as an urban Division with a Rural, Remote & Metropolitan Area Index of 2 (RRAMA2), and stretches along the NSW coast, south of Sydney from Helensburgh to Gerroa. Established in 1993, the Division has 219 members and is recognised as an innovative Division with strong stakeholder ties. A key objective of the IDGP is to work collaboratively with GPs, other health professionals, consumers and community groups to increase the integration of primary health care services within the Illawarra.

Figure 1: Location of Illawarra Division of General Practice



Illawarra region

The Illawarra region is a mix of rural, urban and industrial land and waterways, and encompasses the three Local Government Areas of Wollongong, Shellharbour and Kiama. The resident population in the Illawarra area is approximately 257,000. Some characteristics of the Illawarra community include a high unemployment rate at 9% compared to the NSW rate of 7.2% (ABS, 2002), with 35% of the population under 24 years, and an average family income less than the NSW State average. Around 21% of the population was born overseas, with 15% of the total population speaking languages other than English (ABS, 2002).

Primary Partnerships

IDGP Access to Allied Health Services project

The IDGP was successful in obtaining funding under the BOiMHC Access to Allied Health Services component for the 2003-2004 year and engaged the services of a part-time Senior Clinical Psychologist for the Primary Partnerships project in November of that year.

Training

In order to participate in Access to Allied Health Services projects GPs need to have completed both Familiarisation Training and Level 1 training as per the BOiMHC initiative and be registered with the Health Insurance Commission (HIC). Familiarisation training is designed to inform GPs of the BOiMHC initiative in general while Level 1 training teaches them the skills to perform the 3 Step Mental Health Process (Appendix 1). Registration with the HIC enables GPs to access Service Incentive Payments (SIP) for providing a 3 Step Mental Health Process to a patient. Level 2 training promotes skills and knowledge that enable GPs to deliver Focussed Psychological Strategies (FPS).

At the IDGP 65 GPs completed Level 1 training (61 GPs are currently registered with the HIC), while 21 GPs have completed Level 2 training although this is not an element of the IDGP project. Initially 20 GPs of those 65 who had completed Level 1 training were recruited by the Division to participate in the Primary Partnerships project.

Project reference group

A project reference group was established by IDGP to oversee the development and implementation of the project. The reference group comprised four GP Members of the IDGP, the Director of Illawarra Area Mental Health Services; Director Illawarra Institute for Mental Health; one consumer representative; Director Lifeline South Coast; the GP Share Care Project Officer from Illawarra Area Health Service; IDGP Mental Health Program Officer; IDGP Senior Clinical Psychologist; IDGP Program Development Manager; IDGP Chief Executive Officer; IDGP Youth Health Program Officer and the IDGP Operations Manager. The group met regularly to monitor progress of the project.

Project structure

The following summary describes how the IDGP operates the project once a participating GP has identified a patient with a mental health problem using the 3 Step Mental Health Process (Flowchart Appendix 2).

1. Psychologist receives direct referral from GP via dedicated fax and contacts the patient to make an appointment.
2. Psychologist views referral to check type(s) of focussed psychological strategies (FPS) requested by GP and makes clinical judgement on the type of FPS to deliver.
3. Patient attends six sessions with the psychologist at either the referring GP's rooms, the Division or at another suitable location. A minimum set of data is collected during each visit. An outcome tool, Depression and Anxiety Stress Scales (DASS), is completed before and after six sessions. A co-payment of \$5 per session is collected from each patient by the psychologist.
4. Patient reviewed by GP after receiving progress report from the psychologist.
5. GP refers patient for further six sessions with psychologist, if required. Evaluation of patient's progress is sent to GP at the end of further sessions.

Project changes

Two main changes have occurred over the course of the Primary Partnerships Project. They are:

1. From April 2004, the introduction of trainee psychologist student placements to cope with the demand for clinical services. The number of students participating in the project has ranged from one to five.
2. From March 2005, the service moved to Northfields Clinic at the University of Wollongong where there are more rooms, access to journals, psychometric tests, computers for students and appropriate security is available.

Outcome tools

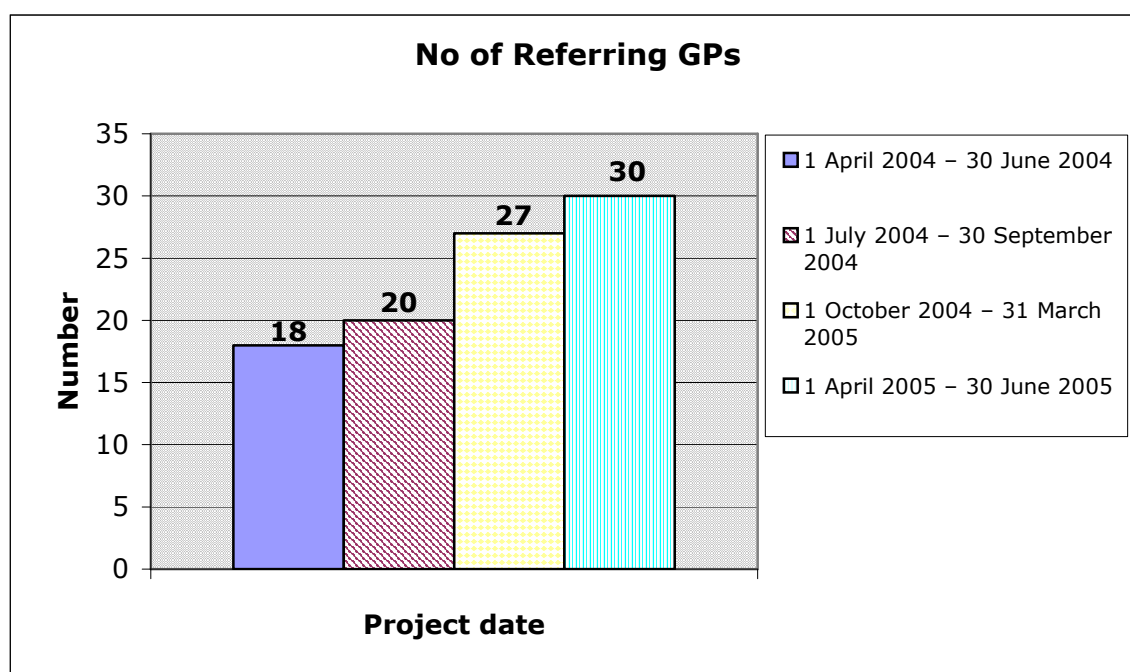
Allied health professionals employed by the Division used the DASS21 outcome tool which is administered at the first and final sessions with clients. The DASS is a self report instrument for measuring depression, anxiety and tension/stress with two versions, a 21 item report (DASS21) and a longer 42 item report (DASS42). See Appendix 3.

Participation

GPs

Of those 65 GPs who were eligible to participate in the project, 20 initially agreed to do so. Over the course of the project this number has increased to 30 (Figure 2), as the number of psychologists available to treat patients has increased. The number of patients that each GP has referred to the service ranges from 1 to 34 with a median of 5 referrals, as at the end of April, 2005.

Figure 2: No of GPs referring patients to allied health professionals



Psychologists

All the allied health professionals involved in the Primary Partnerships project are clinical psychologists who are directly employed by the Division. The number of psychologists employed has increased over the course of the project to accommodate the growing number of referrals to the service, as has the number of trainee psychologists from the University of Wollongong Clinical Psychology Training Programme. In total four clinical psychologists and five students have participated in the project at some point, as shown in the following table.

Table 1: No of Psychologists employed by the IDGP for the Primary Partnerships project

Dates	No of Psychologists Employed	FTE
1 April 2004 – 30 June 2004	3 Clinical Psychologists 1 Intern Clinical Psychologist	1.85
1 July 2004 – 30 September 2004	3 Clinical Psychologists 3 Trainee Clinical Psychology students from UoW on placement.	2.1
1 October 2004 – 31 December 2004	3 Clinical Psychologists 4 Trainee Clinical Psychology students from UoW on placement.	2.1
1 January 2005 – 31 March 2005	3 Clinical Psychologists 5 Trainee Clinical Psychology students from UoW on placement.	2.1
1 April 2005 – 30 June 2005	4 Clinical Psychologists	2.4

Patient participation

From 1 April 2004 to 30 April 2005, 250 patients received treatment with 915 psychology sessions attended.

Evaluation

The Access to Allied Health Services program has funded 102 projects across Australia. Each project is required to collect a minimum data set of information related to patient demographics, participating health care providers and services provided (Kohn et al, 2005). The Program Evaluation Unit at the University of Melbourne is using the data from the minimum data set along with local evaluation reports to conduct a national evaluation of the Access to Allied Health Services Component of the Better Outcomes in Mental Health Care initiative.

The Illawarra Division of General Practice has contracted an external evaluator CEPHRIS (The Centre for Equity and Primary Health Research in the Illawarra and Shoalhaven), University of New South Wales to conduct the local evaluation of their Primary Partnerships project.

Aim

The aim of this evaluation was to examine the impact of the Access to Allied Health Services program in the Illawarra Division of General Practice.

Objectives

The objectives of the evaluation were:

- To investigate whether this model of service delivery meets GP needs for training and delivery of quality mental health services; improves work flow, work patterns and workload for participating GPs, and strengthens the relationship between the Division and local member practices.
- To examine patient, GP and psychologist satisfaction with the project
- To examine any changes in the severity of mental health problems using the DASS21 scores collected by psychologists before and after the series of psychological treatment sessions

Data collection

The data collected was from a mixture of sources including quarterly progress reports from the Division to the Commonwealth. De-identified information was received from the Coordinating Clinical Psychologist regarding patient characteristics and DASS21 scores. Patient satisfaction was examined with a questionnaire and GP and psychologist satisfaction with a semi-structured

interview conducted face to face. The details of these methods and the results are presented in the following sections.

Ethics

The University of New South Wales Human Research Ethics Committee approved this evaluation - Approval No HREC 04091.

Findings

GP Satisfaction with the project

Method of data collection

Invitations to participate in the evaluation process were extended to all participating GPs. Fourteen agreed to participate but due to work and other commitments only 12 GPs were interviewed. Face to face interviews, which took approximately 30 minutes each to complete using a semi-structured questionnaire (See Appendix 6), were conducted at the GPs' own practices at a pre-arranged time and date. Responses which were noted during the interview on paper were later transcribed and analysed thematically using NVIVO software.

Results

Demographics

Of the 12 GPs interviewed 11 were males. All GPs were aged 40 years or over with 5 GPs over the age of 50. The main location of practice for participating GPs ranged from Bellambi in the north of the Division to Gerringong in the south.

The majority of GPs (n=10) graduated in Medicine in Australia; the other 2 GPs graduated overseas. The years of experience working in general practice ranged from 9.5 to 33 years. The majority (n=7) have worked in general practice for more than 20 years. Half of the 12 GPs were fellows of the Royal Australian College of General Practitioners and all but one was vocationally registered.

Two of the 12 GPs were working in general practice on a part time basis, while the remainder worked full time with average hours ranging from 30 to 77 hours per week. Four of the GPs reported working an average of more than 50 hours per week. Ten of the 12 GPs worked in group practices. Of these GPs, the number of practice partners ranged from 2 to 6 GPs.

The majority of GPs (n=10) have undertaken some form of postgraduate training or Clinical Professional Development in mental health in the last 12 months, apart from the BOiMHC familiarisation training. Courses attended included the Level 2 BOiMHC training and 'Teams of Two' training.

Opinions about BOiMHC initiative

Comments from all 12 of the GPs indicated that they were very positive about the overall BOiMHC initiative. Of particular value to them were the practical solutions offered under the initiative such as GP training and access to psychological services. Two of the GPs stated that the training had increased their confidence to manage patients with mental health problems. The Access to Allied Health Services component of the initiative was seen by many of the GPs as a way of providing affordable mental health services to patients who could otherwise not afford them.

Opinions about IDGP Primary Partnerships Project (PPP)

GPs were asked to comment on particular aspects of the Primary Partnerships project. Following are their views:

Assessment tools and the Mental Health Assessment Form

The majority of GPs (n=10) reported using some form of assessment tool such as the K10, DASS, HAD or SPHERE when assessing patients with mental health problems. Seven of the GPs indicated that they had used the Mental Health Assessment Form (Appendix 7) but 4 also mentioned that they did not use it regularly as it was too time consuming to complete.

GPs indicated that these tools were very useful in assisting the assessment process and clarifying or confirming initial thoughts. One GP also commented that the tools helped to reinforce to patients that they were being treated for the right problem and hence improving patient confidence. Most GPs also felt that their assessment skills had improved since they started using these tools.

Referral process

While the majority of GPs (n=11) made positive comments about the referral process, half of them also raised concerns. Positive comments included that the process was simple, efficient and effective. Concerns raised included the ability of the current format to assess risk; long waiting periods, particularly as demand increased, and incidents of referred patients not being contacted by the psychologists in the latter period of the project.

GPs were also asked to comment on the option of referring a patient for 6 additional visits. The majority of GPs (n=7) said they had not referred any patients back for the additional visits. Of these GPs, 2 reported that on occasions

they had wanted to send patients back but were told that the service was not available.

Four GPs reported that they had utilised the 6 additional visits for one or more of their patients. These GPs felt that the option was useful and effective in treating these particular patients.

Communication between GPs and psychologists

Eight of the 12 GPs made positive comments regarding the level of communication between them and the psychologists since the project began. Of particular value were the written reports and informal face-to-face communication when psychologists visited the practice. When asked specifically about the usefulness of these reports, 10 GPs described the reports as thorough and very useful in assessing the progress of their patients.

Most GPs (n=8) felt that there were no barriers to communication with psychologists and one comment was:

"I felt that if I wanted to talk I could just phone them"

The majority of GPs (n=11) also felt that the program created the scope for enhanced communication between GPs and psychologists. When asked how they thought this was achieved, GPs responded that written reports, visits to and involvement in the practice, and the referral relationship had facilitated this enhanced communication. One GP commented:

"Any cross-referral relationship promotes communication"

When asked whether they felt the visiting psychologists had become part of the practice team, 5 GPs responded in the affirmative, 3 thought it would not happen because of the size of the practice, and 2 thought that it had partially occurred or were optimistic that it would happen in the future.

Overall satisfaction with the program

All of the 12 GPs interviewed made very positive comments regarding the program and thought that this model of care should be in place for an extended period. Of particular value was the improved access for patients due to low cost and relatively short waiting lists in comparison with other available psychological

services. GPs indicated that there is a shortage of affordable and prompt psychological services in the area, and emphasised that this program was filling a gap in current service provision. One GP commented:

"There is a niche for this program. It addresses the needs of otherwise healthy patients with mental health problems."

GPs thought that the program was convenient and de-stigmatising for patients because they were able to consult with clinical psychologists in the GP's surgery. Also valued was the opportunity to hand over some of the load and responsibility from GPs who are sometimes not in a position to provide focused psychological treatments to their patients because of time and skill limitations.

The reasons GPs gave for participating in the program were to improve patient outcomes (n=8), improve skills and ability to manage patients with mental health issues (n=4), take pressure off GPs (n=4), and facilitate access to mental health PIP payments (n=1) (More than one reason could be given). Almost all of the GPs felt that these goals had been fully or at least partially achieved.

When asked how effective the program was in improving the clinical outcomes of patients the resounding response was "very effective". One GP explained in detail how this model of care "reduces the burden of further complications down the track." Two GPs noted that the effectiveness of the program was largely dependent on the patient, with ready and willing patients experiencing the greatest level of improvement. Nine of the GPs stated that they were happy with the progress of their patients in this program.

Concerns raised by a number of GPs referred to the long waiting lists that accumulated as the program progressed and a perceived inadequacy of resources to sustain the program.

Two GPs were concerned that by referring their patients to the program they had lost responsibility for the care of their patients. One GP commented:

"They're not the psychologist's patients, they're my patients. I feel very strongly about that."

Further to this comment, a concern raised by a number of GPs was that although patients were being referred back to their GP at the end of the 6 sessions, many patients did not return for review.

Suggestions for improvement

GPs noted a number of aspects of the service that need to be changed and gave a variety of suggestions for improving the program.

A major issue was the sustainability of the program. Suggestions for making this model of care more sustainable included government funding (n=8), a larger patient contribution to cost (n=2), and incorporating it into the Enhanced Primary Care (EPC) model (n=3).

The need to ensure that waiting times are low was mentioned by 2 GPs and one GP suggested that more frequent updates regarding waiting times would be helpful.

Other suggestions for improvement included the provision of brief interim reports to GPs during the psychological treatment phase; encouraging patients to attend follow-up consultations with GPs; expansion of the program to incorporate psychiatric services; developing a means for recalling patients who would benefit from the program and expanding the service to allow referrals from other service providers. Education on how to access government funding was suggested by one GP and another GP thought that computerising the initial assessment tool could be useful.

Two GPs emphasised the need to ensure that the program remains simple and user friendly.

Psychologist Satisfaction with the project

Method of data collection

Data was collected from the clinical psychologists at three points in time. A semi-structured questionnaire (Appendix 8) was used to conduct a group interview with the 3 psychologists and two separate interviews were conducted solely with the Senior Coordinating Psychologist later in the project to assess progress. Responses from these interview sessions are incorporated below.

Results

Demographics

The three psychologists employed by the Division to provide clinical services for this project are all female, registered clinical psychologists. They have had 20, 10 and 3 years experience in clinical practice.

Opinions about BOiMHC initiative

All three psychologists believed the initiative was a good philosophical idea but that access to allied health professionals should be refined to access to clinical psychologists, based on the type of referrals received.

Opinions about IDGP Primary Partnerships Project (PPP)

The psychologists were asked to comment on particular aspects of the Primary Partnerships project. Their views are described below:

Referral process

All of the psychologists expressed satisfaction with the referral process at the initial group interview. They also believed that generally the referrals were appropriate although some referrals were for serious mental illnesses, relationship difficulties and domestic violence. After ten months of operation, the senior coordinating psychologist believed that referrals had slowed and were more appropriate. When asked at the group interview whether the information they received with referrals was sufficient and appropriate, the psychologists commented that the GPs typically failed to fill in all fields on the referral form.

Written progress reports

The psychologists described the requirement of the program to refer patients back to the GP at the end of the 6th consultation with a letter or progress report

as a good opportunity to review the case, goals and efficacy of treatment. It was viewed as an appropriate way to feed back patient progress to the GP as it helped the GP with long term management and enabled them to identify relapse triggers and preventative measures.

All believed that if they wished to talk to a GP about a patient that it was generally easy to do so as they visited the GPs' practices to conduct treatment sessions. When they wished to refer patients on, they informed the GP but made the referral themselves or empowered the patients to make their own referral. Patients have been referred on to Northfields Clinic at the University of Wollongong, Relationships Australia, community mental health agencies or in the case of emergencies, Lifeline.

Communication between GPs and psychologists

The psychologists commented that although communication was one-sided, because they provided services to the GPs' patients, the quality of communication between them and the GPs had improved from previous levels with their visits to the GPs' rooms. The only barrier they identified to communication between themselves and the GPs was time and availability, as both parties had scheduled appointments. However, they did not see this barrier as too much of a problem as patients were a non-urgent client group.

Clinical outcomes of the patients

Generally, the psychologists thought the program has been effective in improving the clinical outcome of the patients as it offers services to patients at minimal cost when they had not previously had any services. Alternatives available to the GPs before the implementation of this project were Northfields Clinic where clients pay \$25, private psychologists, area community mental health services, agencies such as Anglicare and the hospital emergency department. For patients appropriately referred, they believed there had been significant gains although these are yet to be determined long-term. All patients receive treatment on a one-to-one basis. There is no group treatment and there are no services to adolescents or children. They have chosen not to provide group treatment in this project as they see group therapy as a service relatively well resourced in the Illawarra region.

The six session limit was thought by the psychologists to have reduced the efficacy of the program for many patients as the initial sessions were generally

about relationship building, psycho-education and teaching patients some treatment strategies. However, positive aspects described were that sessions help to demystify psychology and make people more likely to pay for treatment in the future, if they can afford to do so.

Remuneration received

Remuneration received by the psychologists was described as satisfactory although they did state that there is a significant gap between what they are paid and the amount set by the Australian Psychological Society (APS) for private psychologists. However, psychologists described the amount paid for professional development and travel to be not as good as it could be. Adequate travel costs are seen as a priority given that "community psychology is about providing services in the community".

Overall satisfaction with the project

Aspects of the project that the psychologists liked were: meeting a need in the community, working in the GPs' practices and being part of a team, instead of working as a sole practitioner. Working in the GPs' surgeries allows the psychologists time to develop relationships with patients and GPs and provide some education to GPs on site.

Less agreeable aspects were described as: the six session limit, lack of physical resources such as psychometric assessment tools, the time required for travel and the physical environment of the GPs' rooms. The ways in which GPs' rooms are set up are sometimes not suitable for psychological work, for example where the desk is a barrier between the psychologist and the patient. The low co-payment (\$5) was also disliked as it was seen as demeaning the project.

Suggestions for improvement

In line with the dislikes noted above, suggestions for improvement of the project included changing the \$5 charge to either nothing or to a more significant amount, changing the way in which the charge is collected, such as billing patients, changing the 6 session limit at the psychologist's discretion and acquiring additional resources including money available for professional development.

In summary, the participating psychologists expressed satisfaction with the project describing it as a great project that fills a gap in the community. They believed that it should be continued through additional government funding.

Patient Satisfaction with the project

Method of data collection

A patient satisfaction questionnaire was developed based on that used by the evaluators of the project conducted by the Southern Highlands Division of General Practice. Using a similar questionnaire allows a comparison of processes and outcomes to be made at the conclusion of the respective projects. Two versions of the patient satisfaction questionnaire were produced; one that was distributed by the psychologists to patients at their final session and another that was mailed out by the Senior Psychologist to those patients who completed some sessions but failed to complete the full six sessions (Appendix 4). Patients were also provided with an information sheet (Appendix 5), along with a stamped addressed envelope so that the completed questionnaire could be returned directly to the evaluators. In all, 120 patients were invited to complete the patient satisfaction questionnaire. No follow-up for completed questionnaires was conducted by the evaluators as only the Senior Psychologist knew the patients' details to maintain confidentiality. The patient satisfaction data was analysed using Excel and NVIVO software.

Results

Completed satisfaction surveys were received from 38 patients (32% response rate). The number of sessions attended by each patient ranged from 3 to 19 sessions with 53% of respondents attending 1-6 sessions. A breakdown of the number of sessions attended by patients is shown in the following table.

Table 2: No of sessions attended by patients who completed the patient satisfaction questionnaire

No of Sessions	No Attended	Percentage
1 – 6	20	53
7 – 12	13	34
>12	4	11
Not recorded	1	2
Total No of Responses	38	100

Thirty-seven percent of patients (n=14) responded that they felt comfortable or very comfortable about consulting a psychologist, 21% (n=8) were uncomfortable or very uncomfortable while the remaining 42% (n=16) were unsure of their feelings when first referred to the psychologist. When asked would they choose to

engage in further treatment from a psychologist, 79% (n=30) responded yes, 8% (n=3) responded no and the remaining 13% (n=5) were unsure.

There were a number of aspects that patients found useful about the sessions with the psychologist. Nearly a third of patients (n=12) mentioned practical strategies such as relaxation techniques, learning to challenge negative thoughts and other coping skills as the most useful aspect. Six patients noted that having someone to talk to freely was most useful and an equal number mentioned that sessions with the psychologist helped them to gain insight into their mental health issues.

In response to what they found least useful about the sessions with the psychologist, 45% of respondents (n=17) noted nothing was least useful. Three patients mentioned the limited number of sessions available, 1 the venue for sessions (GP's surgery) and another paying only \$5 for treatment as it demeans the counselling service and its practitioners. One patient also noted that the psychologist and GP had differing opinions about the effectiveness of the medication the patient was taking.

In answer to how they came to explore mental health issues with their GP, 53% percent of respondents (n=20) noted their mental health issues were raised in regular visits; nine mentioned pre-existing conditions and five mentioned crisis situations that caused them to seek help.

Eighty-seven percent of respondents (n=33) were prescribed medication by their GP for their mental health problems and at the time of completing the questionnaire 66% (n=25) were taking their medications.

All who responded (n=37) believed that their GP had explained why they were being referred to a psychologist and 92% (n=33) felt that their GPs and the psychologists were working together to assist them.

On a 10 point rating scale where 1=worst and 10=best, patients were asked to rate their mental health status before and after treatment. One patient rated their mental health status as unchanged, one patient rated it as better before treatment than after, while the remainder (n=36) rated their mental health status as better after treatment. The mean pre-treatment score was 2.64 and the mean post-treatment score was 7.59.

Patients were asked to express their agreement with several comments regarding various aspects of the project as shown in Table 3. The proportions shown are the patients who **agreed** or **completely agreed** with the statement.

Table 3: Patient responses to statements about project

Statement	N	%
My GP was very supportive in helping me to explore my mental health problems	37	97
I did not understand the purpose of attending sessions with a psychologist	6	16
Prior to this referral I did not know that a psychologist could help me deal with my problems	10	26
Getting to the psychologist's office was very difficult for me	14	37
The sessions provided by the psychologist were well structured	36	95
The treatment provided by the psychologist helped me to deal with my problems	35	92
I am psychologically much better since I started the sessions with the psychologist	32	84
I would definitely recommend this program to others	36	95
If I had the finances and were able to pay for such treatment, I would still attend	28	74

Overall satisfaction with project

To summarise, the overall satisfaction with the project by patients who completed the survey was high. The following two final comments illustrate their satisfaction with the project.

"The program was convenient and affordable while also being well-structured and effective. I received excellent advice and skills that help me deal with my particular situation."

"Having an affordable, accessible service like this continue would really breakdown the negative image of seeing a psychologist. It is such a beneficial preventative program! I would never have seen a psychologist without it!"

Demographic characteristics of participating patients

Method of data collection

From the beginning of the project until 30th April 2005, 250 patients received treatment from the participating psychologists. Data submitted to the minimum data set maintained by the national evaluators was passed onto the local evaluators in a de-identified form by the Senior Clinical Psychologist working on the project.

Results

Seventy one percent of patients were females. The mean age of patients was 40.5 years (sd = 14.15, range 70 [15-85]). Table 4 shows the age distribution.

Table 4: Age distribution of participating patients

Age	Frequency	Percent
<30	64	25.6
30-39	66	26.4
40-49	51	20
50-59	42	17
60-69	15	6
≥70	10	4
Missing	2	1
Total	250	100

Ninety-one percent of patients (n=227) were recorded as speaking English at home with no data recorded for the remaining 9% (n=23) of patients.

Clinical details and outcomes of participating patients

Method of data collection

The Senior Psychologist provided two types of de-identified data to the local evaluators. The first was from the minimum data set on the duration of sessions and co-payment amounts. The second was the pre and post DASS21 scores for each of the patients. The DASS21 was administered by the clinical psychologists at the first visit and again at the 6th and/or 12th session to assess the progress of patients.

Results

The majority of sessions (71%) conducted by the psychologists were of 46-60 minutes duration and there was no co-payment made by patients for a majority of the sessions (42%), although data was not collected for 267 sessions (29%). A breakdown of the duration of sessions and co-payment amounts is provided in the following tables.

Table 5: Duration of sessions with psychologists

Session Duration	Frequency	Percent
0-30mins	61	7
31-45mins	7	1
46-60mins	649	71
>60mins	167	18
Missing	31	3
Total	915	100

Table 6: Co-payment amounts paid by participating patients

Co-Payment Amount	Frequency	Percent
\$0	383	42
\$5	228	25
\$10	34	3.7
\$15	1	0.1
\$20	2	0.2
Missing	267	29
Total	915	100

The mental health disorders most commonly recorded for the participant patients were anxiety or depression. Some patients had more than one disorder. Three patients were found to be psychotic and another three had bipolar disorder. Other problems specified included grief (n=3) and personality disorder (n=3).

DASS21 scores from the first session were available for 140 of the 250 patients treated up to April 30 2005 and post treatment DASS21 scores were available for 75 patients. Pre and/or post DASS21 scores were unavailable because either the psychologist did not record them, the patient dropped out, or treatment was not

yet completed. Analysis of the pre and post DASS21 scores indicated an improvement in the patients' mental health status as shown in Table 7.

Table 7: Pre and Post DASS21 score statistics

Statistic	Pre DASS21 Score	Post DASS21 Score
N	140	75
Mean	30	14
Median	32	12.5
Mode	32	6
Std. Deviation	13.96	10.08
Range	62	51
Minimum	0	0
Maximum	62	51

Discussion

The aim of this evaluation was to examine the impact of the Access to Allied Health Services program in the IDGP. There were two areas of the evaluation, one related to the satisfaction of all involved parties with the program and the second with describing the patients and their outcomes. Overall, the findings show that the program has been successful in both of these areas.

GP satisfaction

The interviewed GPs were positive about the overall BOiMHC initiative, valuing the practical solutions it offered such as GP training and education, and access to psychological services. The Access to Allied Health Services component of the initiative was seen by many of the GPs as a way of providing affordable mental health services to patients who could not otherwise afford them.

One of the objectives of this evaluation was to investigate whether the model of service delivery used in this project met GP needs for training and delivery of quality mental health services; improved work flow, work patterns and workload for participating GPs; and strengthened the relationship between the Division and local member practices. Therefore, participating GPs were asked to comment on particular aspects of the Primary Partnerships project conducted by the Division.

While the majority of GPs reported using some form of assessment tool when assessing patients, there was no one uniform tool cited. Tools used included the K10, DASS, HAD and SPHERE assessment tools. Seven of the GPs indicated that they had at some time used the Mental Health Assessment Form, however some also mentioned that they did not use it regularly as they found it too time consuming to complete or they found it too clinical and hence not particularly suitable for use in a general practice setting. Regardless of the assessment tool used, seven of the GPs believed that using their chosen tool had improved their assessment skills.

With regard to the referral process whereby GPs directly refer patients to the psychologists using a dedicated fax line, the majority of GPs were positive about the process describing it as *simple, runs smoothly, efficient, and easy to use*. The main concern raised about the referral process was the lengthy waiting periods, particularly as demand for the service increased.

Communication between the GPs and psychologists was also viewed in a positive light by most of the GPs. Ten GPs described the written progress reports from the psychologists after the 6th session with the patient as being very useful in assessing the progress of their patients. The value of informal and immediate feedback that occurs when the psychologist comes to the practice was also noted by some GPs, although such feedback may not be available to those GPs who work part-time or have a heavy workload. Overall, the GPs felt that the program had created the scope for enhanced communication between themselves and the psychologists through these written reports, visits to the practice and the referral relationship in general.

A majority of GPs believed the program was effective in improving the clinical outcomes of patients and were happy with the progress of their patients in the program. Their comments about improved clinical outcomes were also supported by their assertions that their goals for participating in the program were attained. In particular, they felt that through participation in the program their skills and ability to manage patients with mental health issues were enhanced; some of the pressure was taken off their workloads, and patient outcomes were improved.

To summarise, GPs interviewed for this evaluation expressed a good deal of satisfaction with the BOiMHC initiative and the Access to Mental Health Care component of the initiative. The model of service delivery used by IDGP was also viewed positively with GPs believing that the referral process, written progress reports and practice visits by the psychologists created scope for enhanced communication between GPs and psychologists and that the program was effective in improving the clinical outcomes of patients. Although only a small number of local practices participated in this project, such positive views have the potential to improve work flow, work patterns and workload for participating GPs, and to further strengthen the relationship between the Division and local member practices.

Psychologist satisfaction

All three psychologists believed the BOiMHC was a good idea in theory but that access to allied health professionals should be refined to access to clinical psychologists, based on the type of referrals received. Given the predominance of patients with anxiety and depression this may be a valid point.

With regard to the Primary Partnerships project in particular, they believed that generally the referrals were appropriate although some referrals were for serious mental illnesses, relationship difficulties and domestic violence. As referrals slowed after the initial implementation of the project, they became more appropriate. This may be due to the GPs' increasing skills and ability in using the assessment tools described above.

Written progress reports to be completed after the sixth session were seen as a good opportunity to review a case, goals and efficacy of treatment and an appropriate way to feed back patient progress to the GP. The quality of communication between themselves and the GPs was also improved through practice visits, as working in the GPs' surgeries allowed the psychologists the time to develop relationships with both the GPs and patients and provide some education to GPs on site.

While remuneration received by the psychologists was described by them as satisfactory, there was less satisfaction with the amount paid for professional development and travel and the level of resources available, such as psychometric assessment tools. Some of these areas of dissatisfaction have been addressed with the move of the psychological team to Northfields Clinic at the University of Wollongong. For example, at the clinic there are more rooms available and easy access to professionals journals and psychometric tests. However, additional money for professional development and travel requires greater funding for the program. Whilst the five students were working for the service, two of the psychologists were providing supervision to the students to keep costs down but this is a time consuming requirement for which they felt they were not being adequately paid.

Overall the psychologists thought the project has been effective in improving the clinical outcome of the patients because it offers services to patients at minimal cost when they had not previously had any services. However, the six session limit was thought to have reduced the efficacy of the program for many patients as it does not take into account the time required for relationship building, psycho-education or teaching strategies to patients.

In summary, the project was described by the participating psychologists as a great project that fills a gap in the community. As such it provides a good degree

of satisfaction for them as they feel that they are providing a service within the local community by working in the GPs' practices and being part of a team.

Patient satisfaction

The patient satisfaction questionnaire covered a variety of issues. Overall, the feedback from participating patients was very positive. Despite only 37% of patients stating that they felt comfortable about consulting a psychologist when first referred by their GP, 92% agreed that the treatment provided by the psychologist helped them to deal with their problems, and 78% agreed that if they had the finances and were able to pay for such treatment, they would do so.

The majority believed that their GP had explained why they were being referred to a psychologist, yet 16% also agreed that they did not understand the purpose of attending sessions with a psychologist. This may be an indication that patients are accepting the recommendation of their GP without fully understanding the nature of psychological treatments or their efficacy. Such discrepancies in responses may support the psychologists' call for greater discretion with the six session limit so that psycho-education can occur in a beneficial manner.

Over 90% of the patients who completed the satisfaction questionnaire felt that the psychological sessions were well structured and useful. Aspects of the sessions that patients found useful were learning practical strategies and gaining insight into their mental health issues. Ninety-seven percent also agreed that their GP had been very supportive in helping them explore their mental health problems. Thirty seven percent of patients agreed that getting to the psychologist's office was very difficult for them. Given that many of the psychologist's sessions were conducted at the GPs' rooms, the level of agreement with this statement may be about the confronting nature of psychological sessions as well as issues about physical access, for as two of the GPs commented patients have to be ready and willing for treatment for it to be effective.

When asked to rate their mental health status before and after treatment, 95% indicated self reported improvement and 95% also agreed that that they would definitely recommend the program to others. Therefore, it may be surmised that those patients who completed the patient satisfaction questionnaire were happy with the project and the treatment they received from their GP and the psychologist.

Demographics of patients

The demographics of participating patients show a predominance of women (72%) and that over 50% of patients were under the age of 40. Ninety one percent of patients were recorded in the minimum data set as speaking English at home. With around 21% of the Illawarra population born overseas, and 15% of the total population speaking languages other than English (ABS, 2002), the large number of patients speaking English at home suggests that the project has not reached all sections of the local population.

Mental health status

The clinical status of the patients was assessed by the psychologists using DASS21 measures. The most common mental health disorders recorded for participating patients were anxiety and depression. There was also a degree of co-morbidity for these disorders. Although analysis of the pre and post DASS21 scores showed improvement in the mental health status of patients, missing treatment scores for many patients makes effective comparison of pre and post treatment scores problematic. For example, there may be some bias due to the fact that a number of the missing post treatment scores may well be missing because these patients were not responding to treatment and dropped out. If this program is to be continued, an effective method of recording psychologists' assessment scores for patients must be implemented so that patient outcomes can be monitored.

Conclusion

The Access to Allied Health Services program in the IDGP has been shown to go some way towards meeting GP needs for training and delivery of quality mental health services and to have the potential to improve workflow, work patterns and workload for participating GPs. The model of service delivery adopted by the Division whereby patients are directly referred from GP to psychologist; psychologists are employed by the Division and travel to GP practices has been shown to be effective in providing low cost care to patients who previously had no access to such services. All participating parties in this evaluation expressed a high degree of satisfaction with the program and there was strong support for the program to continue and expand.

To date only 30 GPs have been able to refer to the program due to resource constraints. Sixty-five GPs are qualified to refer and the Division has 219 members. In comparison with other disease specific programs in the IDGP this level of interest and engagement is second only to the shared care maternity program. It therefore seems likely that if the program continues and in the light of the evidence about patient outcomes, demand for psychological services is likely to outstrip supply unless further resources are made available.

Evidence from GPs, psychologists and patients suggests that the program leads to improved patient outcomes in a context where most patients are treated by the GP through medications and where the psychologist uses agreed therapies at the same time. This seems to act as a stronger incentive to GPs than the 3-step process that depends on the patient returning to the GP after therapy if the GP is to claim the incentive payment.

The referral process has taken some time to settle with some referrals of patients with inappropriate conditions, such as those with psychotic symptoms, in the early months. There is room for further consideration of the boundaries of the program including the six session blocks, the range of therapies included and the definition of appropriate referrals.

References

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Kohn, F., Morley, B., Pirkis J., Blashki, G. & Burgess, P. (2005) Evaluating the Access to Allied Health Services Component of the Better Outcomes in Mental Health Care Initiative Fourth Interim Evaluation Report. Melbourne: Program Evaluation Unit, School of Public Health University of Melbourne.

Appendices

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

Appendix 2: Flow Chart for Psychologists

Appendix 3: DASS21

Appendix 4: Patient Satisfaction Questionnaire

Appendix 5: Patient Information Sheet

Appendix 6: GP Satisfaction Questionnaire

Appendix 7: Mental Health Assessment Form

Appendix 8: Psychologist Satisfaction Questionnaire

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

Source: Kohn et al., 2005

Component 1: Education and training for GPs

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

Component 2: The 3 Step Mental Health Process

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

Component 3: Focused Psychological Strategies

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

Component 4: Access to Allied Health Services

The Access to Allied Health Services component enables GPs registered who are registered with the Better Outcomes in Mental Health Care initiative to refer consumers to allied health professionals who deliver Focused Psychological Strategies. Allied health professionals have been defined to include psychologists, social workers, mental health nurses, occupational therapists and Aboriginal and Torres Strait Islander health workers.

The Focussed Psychological Strategies provided by these allied health professionals are the same as those provided by GPs (see above). These services are deliverable in up to six time-limited sessions with an option for up to a further six sessions following a mental health review by the referring GP. Divisions of

General Practice act as fundholders in this component of the Better Outcomes in Mental Health Care initiative.

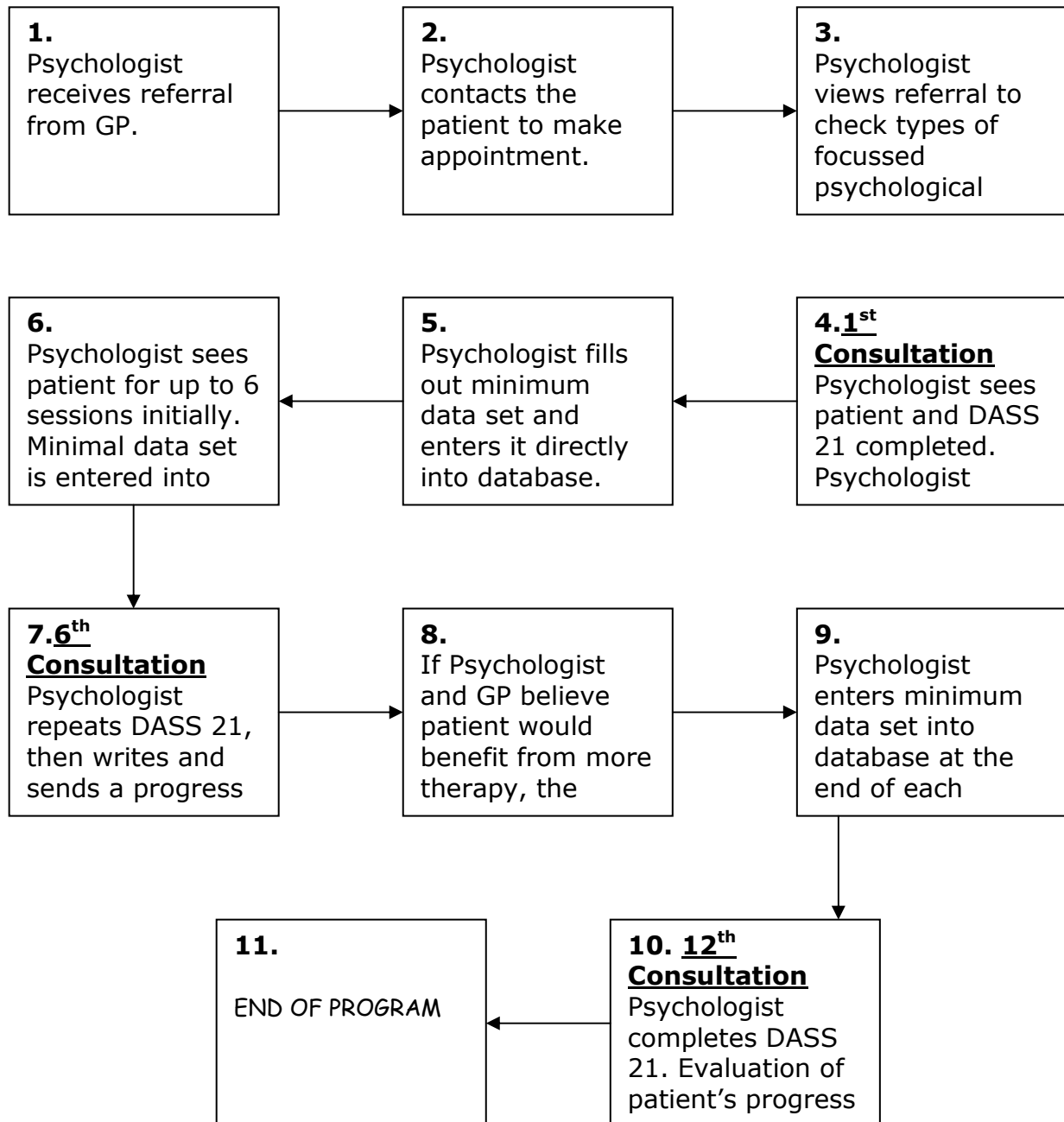
Component 5: Access to Psychiatrist Support

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

Appendix 2: Flow Chart for Psychologists

Illawarra Division of General Practice

Flow Chart for Psychologists- "Primary Partnerships" Program



Appendix 3: DASS21

<h1 style="margin: 0;">DASS₂₁</h1>	<i>Name:</i>	<i>Date:</i>
<p>Please read each statement and circle a number 0, 1, 2 or 3 which indicates how much the statement applied to you <i>over the past week</i>. There are no right or wrong answers. Do not spend too much time on any statement.</p> <p><i>The rating scale is as follows:</i></p> <p>0 Did not apply to me at all 1 Applied to me to some degree, or some of the time 2 Applied to me to a considerable degree, or a good part of time 3 Applied to me very much, or most of the time</p>		
1	I found it hard to wind down	0 1 2 3
2	I was aware of dryness of my mouth	0 1 2 3
3	I couldn't seem to experience any positive feeling at all	0 1 2 3
4	I experienced breathing difficulty (eg, excessively rapid breathing, breathlessness in the absence of physical exertion)	0 1 2 3
5	I found it difficult to work up the initiative to do things	0 1 2 3
6	I tended to over-react to situations	0 1 2 3
7	I experienced trembling (eg, in the hands)	0 1 2 3
8	I felt that I was using a lot of nervous energy	0 1 2 3
9	I was worried about situations in which I might panic and make a fool of myself	0 1 2 3
10	I felt that I had nothing to look forward to	0 1 2 3
11	I found myself getting agitated	0 1 2 3
12	I found it difficult to relax	0 1 2 3
13	I felt down-hearted and blue	0 1 2 3
14	I was intolerant of anything that kept me from getting on with what I was doing	0 1 2 3
15	I felt I was close to panic	0 1 2 3
16	I was unable to become enthusiastic about anything	0 1 2 3
17	I felt I wasn't worth much as a person	0 1 2 3
18	I felt that I was rather touchy	0 1 2 3
19	I was aware of the action of my heart in the absence of physical exertion (eg, sense of heart rate increase, heart missing a beat)	0 1 2 3
20	I felt scared without any good reason	0 1 2 3
21	I felt that life was meaningless	0 1 2 3

Appendix 4: Patient Satisfaction Questionnaire

Illawarra Division of General Practice
Better Outcomes in Mental Health Care
Patient Satisfaction Questionnaire



■ Firstly, some questions about your sessions with the Psychologist:

1. How many sessions did you have with the Psychologist? _____

2. At the start, how comfortable did you feel about consulting a Psychologist?
(Please circle the most appropriate)

Very comfortable with the idea	Comfortable	Unsure	Uncomfortable	Very uncomfortable with the idea
1	2	3	4	5

Comments (if any):

3. What was most useful about the sessions with the Psychologist?

4. What was least useful about the sessions with the Psychologist?

5. Would you choose to engage in further treatment from a Psychologist?

Yes No Not sure

6. Do you have any other comments about your treatment from the Psychologist?

■ Now some questions about your satisfaction with the help your GP provided you with for your mental health care:

7. How did you come to explore your mental health issues with your GP?

8. Did your GP prescribe you any medication for your mental health problems?

Yes No Not sure

9. Are you currently taking this medication for your mental health problems?

Yes No Not sure

10. Did the GP explain to you why you were being referred to a psychologist?

Yes No Not sure

11. Did you feel that your GP and the Psychologist were working together to assist you?

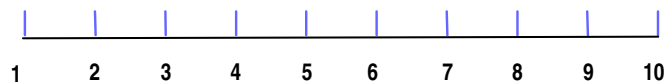
Yes No Not sure

Comments (if any):

■ We would like to ask you to rate your mental health status before and after participation in this treatment program.

12. Think about the week before you were referred by your GP to the Psychologist. How would you have rated your mental health in that week?

Please indicate on the scale from 1 to 10, where 1 is the worst you have felt and 10 is the best you have felt:



13. How would you rate your overall mental health now after consultation with the Psychologist?

Please indicate on the scale from 1 to 10, where 1 is the worst you have felt and 10 is the best you have felt:



Now for some general information

14. We would like your ratings of some aspects of your health care.

Please indicate how strongly you agree or disagree with each of the following statements (indicate your agreement or disagreement with each statement in the appropriate box where 1 is completely disagree and 5 is completely agree)

	I disagree completely	I disagree	I am not sure	I agree	I agree completely
My GP was very supportive in helping me to explore my mental health problems	1	2	3	4	5
I did not understand the purpose of attending sessions with a psychologist	1	2	3	4	5
Prior to this referral I did not know that a psychologist could help me deal with my problems	1	2	3	4	5
Getting to the psychologist's office was very difficult for me	1	2	3	4	5
The sessions provided by the psychologist were well structured	1	2	3	4	5
The treatment provided by the psychologist helped me to deal with my problems	1	2	3	4	5
I am psychologically much better since I started the sessions with the psychologist	1	2	3	4	5
I would definitely recommend this program to others	1	2	3	4	5
If I had the finances and were able to pay for such treatment, I would still attend	1	2	3	4	5

Would you like to make any comment about the program?

Thank you very much for your time. Would you like to receive a summary of the final report on the program?

Yes No

Now that you have completed the questionnaire, please place it in the attached stamped, self-addressed envelope and mail it back to us at CEPHRIS.

Appendix 5: Patient Information Sheet

The University of New South Wales
Centre for Equity and
Primary Health Research in the Illawarra and
Shoalhaven
(CEPHRIS)

Approval No HREC
04091

INVITATION TO PARTICIPATE: PATIENTS

Better Outcomes in Mental Health: Illawarra Division of General Practice
An Evaluation

The Illawarra Division of General Practice in association with the University of NSW is evaluating the program through which you have been receiving therapy, to demonstrate the benefits to patients and GPs and to inform the further development of these services for the people of the Illawarra.

Now that you have completed your treatment with the Psychologist we would like to ask you to provide feedback on the services that you received. Any information that is obtained in connection with this study and that can identify you will remain confidential and will be disclosed only with your permission, except as required by law.

The results will be presented in the final report that shall be available to the public. They may also be published in a number of journals and presented at conferences and seminars. In any publication or presentation, information will be presented in such a way that you will not be identified.

Your participation is important to us. It is voluntary and if you decide not to participate it will not affect your treatment in any way or prejudice your future relations with The University of New South Wales or CEPHRIS. We will ask you some questions that we would like you to comment on and ask you to rate how you felt about aspects of your referral and treatment. Once you have completed the questionnaire please return it by sealing it in the stamp self-addressed envelope attached and mailing the envelope to us at CEPHRIS.

If you require further information about this questionnaire or about the program in general please contact Lesley Hare, Research Assistant on 4226 7052.

Complaints about the research process may be directed to the Ethics Secretariat, The University of New South Wales, phone: (02) 9385 4234, Fax: 9385 6648 or email: ethics.sec@unsw.edu.au

Appendix 6: GP Satisfaction Questionnaire

Illawarra Division of General Practice
Better Outcomes in Mental Health Care
GP Questionnaire for Semi-Structured Interviews

We would like to start with some demographics that we can use for comparison with other Better Outcomes in Mental Health Care programs.

Age (30+, 40+, 50+, 60+, 70+)	: _____
Gender	: female / male
Country where graduated in medicine	: _____
Years as a GP in Australia	: _____
FRACGP?	: Yes / No
Vocational registration?	: Yes / No
Number of hours per week in general practice? So you work?	: _____ : FT/PT
Post code of the GP's main place of practice	: _____
How many GPs work (including the GP) in that practice?	: _____
Any postgraduate training or CPD on mental health in the past 12 months other than <i>Familiarisation Training</i> for BOMH Care initiative	: Yes / No
If yes, what?	_____

- Q1. What do you think of the "Better Outcomes in Mental Health Care" initiative?
- Q2. During the first (assessment) step of the 3 Step Process did you use K10/DAS/other to assess your patients with mental health problems? How useful did find this tool?
- What about the "Mental Health Assessment Form" – Did you use it?
If yes, how useful was this tool?
If no, why didn't you use it?
- Do you think your assessment skills have improved since you have started using those tools? How?
- Q3. Under the *Primary Partnerships* program you had the opportunity to refer your patients with mental health problems to a psychologist for treatment. Patients were entitled to 6 consultations with the psychologist at minimal cost to them.
- How do you feel about this program?
What did you hope to achieve by taking part in this program?
Were the goals achieved?
Do you have any comments on the referral process?

Better Outcomes in Mental Health: An evaluation of the IDGP Programme

- Q4. After the 6th consultation with the psychologist your patients were referred back to you for review. The psychologist also provided you with a written progress report. How useful did you find these reports in assessing the progress of your patients?

Did you use K10 and the Psychologist's progress report to assess the progress of your patients?

If yes, how useful were these tools in assessing progress?

If no, why not?

- Q5. After the review, you also had the opportunity to refer your patients for 6 additional visits to the psychologist. Did you find that your patients generally needed further referral? How did you find this process?

- Q6. How do you feel about the level of communication between you and the psychologists?

Do you think this program has created the scope for enhanced communication between GPs and psychologists? How?

Was there any barrier to communication between you and the psychologists?

Do you feel that the visiting psychologist had become part of the practice team?

- Q7. How effective do you think the program was in improving the clinical outcome of your patients?

Are you happy with the progress made by your patients who have gone through the program?

Why? / Why not?

- Q8. Overall, how satisfied were you with the program? What did you like? What did you dislike?

Are you happy with the financial incentives for taking part in this program?

Was the mental health training required of you to take part in this program appropriate?

- Q9. Are there any aspects of the program that you would like to see changed? If yes, what? Why?

- Q10. Do you think this model of care should be in place for an extended period?

How do you think this model of care can be made sustainable?

- Q11. Do you have any other comments?

Appendix 7: Mental Health Assessment Form

MENTAL HEALTH ASSESSMENT		
Patient Name		
Gender		
Aboriginal or Torres Strait Islander origin		
GP	Practice postcode	
Date of Assessment		
Outcome Tool Used		Result

Problem	Diagnosis
1.	
2.	
3.	

Mental Health History / Treatment	
From Medical Director Notes	
Other Relevant Information	
Has the person ever received specialist mental health care	
Language spoken at home	
How well does the person speak English (Answer will guide decision to involve interpreter assistance)	
Medications	
From Medical Director Notes	
Other Relevant Information	
Family History of Mental Illness	
From Medical Director Notes	
Other Relevant Information	
Medical Conditions	
From Medical Director Notes	
Other Relevant Information	
Social History	
Does the person live alone	Is the person a low income earner
From Medical Director Notes	
Other Relevant Information	

Abuse History - Substance /sexual/physical			
From Medical Director Notes			
Alcohol use:			
Tobacco use:			
BMI:			
Other Relevant Information			
Allergies			
From Medical Director Notes			
Other Relevant Information			
Personal History (eg childhood, education, relationship history, coping with previous stressors)			
Highest education level completed			
Other Relevant Information			
Relevant Physical and Mental Examination from Medical Director Notes			
Other Relevant Examination Information			
Other Relevant Investigations			
Mental Status Examination			
Appearance and General Behaviour	Mood Depressed / Labile		
Thinking (Content / Rate / Disturbances)	Affect Flat / Blunted		
Perception (Hallucinations etc)	Sleep (Initial Insomnia / Early Morning Wakening)		
Cognition (Level of consciousness / delirium / intelligence)	Appetite (Disturbed Eating Patterns)		
Attention / Concentration	Motivation & Energy		
Memory (Short & Long term)	Judgement (Ability to make rational decisions)		
Insight	Anxiety Symptoms (Physical & Emotional)		
Orientation (Time / place / person)	Speech (Volume / Rate / Content)		
Risk Assessment			
Suicidal ideation		Suicidal intent	
Current plan		Risk to Others	
Key Family Contact/Support			

Better Outcomes in Mental Health: An evaluation of the IDGP Programme

FORMULATION – Main problem/diagnosis	ICD – 10 Provisional Diagnosis
	F1 Alcohol & Drug Use disorder Yes/ No
	F2 Psychotic Disorder Yes/ No
	F3 Depression Yes/ No
	F4 Anxiety Disorder Yes / No
	F5 Unexplained Somatic Disorder Yes / No
	Other / Unknown: Yes / No

Patient Education	Yes / No
Eligibility for the Better Outcomes in Mental Health Care initiative	Yes / No
Date for Mental Health Plan Appointment:	

Appendix 8: Psychologist Satisfaction Questionnaire

Illawarra Division of General Practice

Better Outcomes in Mental Health Care

Psychologist Questionnaire for Semi-Structured Interviews

1. What do you think about the Better Outcomes in Mental Health Initiative?
2. GPs have referred patients to you as part of the initiative:
 - a. What do you think about the referral process?
 - b. Were the referrals to you generally appropriate? If not why not?
 - c. Was the information you received with the referrals sufficient and appropriate? If not, what other information would you have liked?
3. At the end of the 6th consultation you were required to refer patients back to the GP with a letter or progress report. What do you think about this process?
 - a. Is the written report an appropriate way to feed back to the GP about the patient's progress?
 - b. Did you feel like talking to the GP about any patient? If so was the GP easily contactable?
 - c. If you recommended further psychologist care in your report was this properly followed up.
4. How do you feel about the quality of communication between you and the GPs?
 - a. Do you feel that the program has enhanced communication between GPs and yourselves/psychologists? If so how?
 - b. Was there any barrier to communication between you and the GPs?
5. How effective do you think the program has been in improving the clinical outcome of the patients?
 - a. Are you happy with the progress made by the patients who have gone through the program? Why? Why not?
6. Do you think one on one therapy provides better clinical outcomes for patients compared to group therapy? Why? Why not?
7. How do you feel about the remuneration that you have received for participating in this project?
8. We are interested in your overall impression of the program. What are the things you liked about the program and what are the things you disliked?
9. Are there any aspects of the program you would like to see changed? If yes what and why?
10. Do you think this model of care should be in place for an indefinite period?
11. How do you think this model of care can be made sustainable?
12. Do you have any other comments?