Access to Allied Psychological Services Program in the Macarthur Division of General Practice

Evaluation Report 2005-06

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Table of Contents

	Page No
Foreword	1
Acknowledgements	1
Executive Summary	2
1. Introduction	3
2. Background	4-5
3. Macarthur Division of General Practice	6-8
4. ATAPS program MDGP	9-10
5. Evaluation	11
6. Demographics of the participating patients	12-13
7. Clinical diagnosis and clinical outcomes of the participating patients	14-18
8. Patient satisfaction with the program	19-22
9. GP satisfaction with the program	23-26
10. Psychologist satisfaction with the program	27-30
11. Discussion	31-37
12. Conclusion	38
13. Reference	39-40

List of Tables

	Page No
1. Population proportions by age	7
2. Program Numbers	10
3. Age distribution of participating patients	12
4. Patients place of residence	13
5. Education levels of participating patients	13
6. Diagnoses of participating patients	14
7. Pre & Post K 10 scores	15
8. K10 scores & levels of anxiety & depressive disorder by proportion of patients	15
9. Pre & Post DASS42 scores statistics	16
10. Level of depression from Pre & Post DASS42 scores by proportion of patients	17
11. Level of anxiety from Pre & Post DASS42 scores by proportion of patients	17
12. Level of stress from Pre & Post DASS42 scores by proportion of patients	17
13. Aspects of psychologists sessions liked by the patients	19
14. Change in patient rating of Pre & post treatment mental health	20
15. Patients' responses to statements about program	22
16. Demographic characteristics of surveyed GPs	23
17. GP preferences for future funding options	26
18. Demographic characteristics of surveyed psychologists	27
19. Psychologists preferences for future funding options	30

List of Figures

Map of Macarthur 6

List of Appendices

1. Flowchart for GPs
2. Flowchart for psychologists
3. Mental Health Referral Assessment Plan
4. Patient Consent Form
5. Patient Progress Report
6. Psychologist Sessional Data and Client Information Form
7. Mental Health Plan and Review
8. Authority for Additional Psychological Sessions
9. K10
10. DASS
11. Patient Satisfaction Survey
12. Participant GP Survey
13. Participant Psychologist Survey

Foreword

This report presents an evaluation of the Macarthur Division of General Practice's Access to Allied Psychological Services program 2005-06. The Macarthur Division contracted the University of New South Wales through the General Practice Unit, Sydney South West Area Health Service to conduct this evaluation. Data collection, analysis and writing of the report were conducted by Mr Iqbal Hasan, Project Officer and Dr Sanjyot Vagholkar, Staff Specialist. Professor Nicholas Zwar provided advisory assistance.

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Executive Summary

The Better Outcomes in Mental Health Care initiative introduced in 2001 has five components, one of which is the Access to Allied Psychological Services program. The program allows GPs to refer patients with mental health problems for focussed psychological treatment with allied health providers such as psychologists.

The Macarthur Division of General Practice received funding in 2004 to establish an Access to Allied Psychological Services program in its region. The program became operational in late 2004 and started to accept referrals in February 2005. The model chosen for retention of psychologists was private contract and clinical services were provided in their rooms. Referral was made directly from GP to psychologists.

Since the program began 15 GPs have referred 316 patients to 23 psychologists. Demand has been strong necessitating a brief cessation of the program in late 2005 and early 2006 in order to remain within budget. The majority of patients referred have been female with a mean age of 35 years. There were a significant number of patients of Aboriginal and Torres Strait Islander origin reflecting the profile of the Macarthur region. Over half of those referred were classified as low income earners.

The main reasons patients were referred to the program were depression and anxiety. Pre-treatment psychological scores showed high levels of distress and the limited post-treatment data available showed good improvement.

There was very limited patient satisfaction data available for analysis. That which was available showed patients were happy with the services provided by both the psychologists and their own GPs. They reported improvement in their mental health following treatment.

Amongst the GPs and psychologists there was a consensus that the program provided an invaluable addition to referral options for patients with mental health problems and importantly, enabled those with limited financial means to access private psychology services. There were some concerns raised about administrative issues and the processes of the program which the Division would benefit from considering in future planning. Both groups supported continuation of the program and most felt this was only possible with government funding.

1. Introduction

The Macarthur Division of General Practice (MDGP) has been operating an Access to Allied Psychological Services (ATAPS) program since late 2004 with patient referrals commencing February 2005. This report presents the findings of the evaluation of the program conducted by the University of New South Wales. It outlines the background to the program, profiles the Macarthur region and Division and describes the ATAPS program in the MDGP. Patient demographics and clinical outcomes are presented together with patient, GP and psychologist satisfaction with the program. The discussion draws together these findings to provide a picture of the impact of the first year of operation of the Macarthur ATAPS program.

2. Background

2.1 Mental health

Mental health disorders are common in Australia with the National Survey of Mental Health and Wellbeing showing almost one in five adults would experience a mental illness at some time in their life.[1] They are a leading cause of non-fatal burden and disease.[2] The most recent National Health Survey estimated the prevalence of long-term mental health problems at 10% of the population and 3.8% of the population reported high levels of psychological distress.[3]

Amongst mental health disorders, anxiety and mood problems are the commonest ones reported and are more common in women than in men.[3] Co-morbidity is also quite frequent with one in four people with a mental health problem experiencing at least one other mental health problem.[4]

People with mental health problems, particularly mood and anxiety disorders, are most likely to consult with a general practitioner (GP) if they opt to see a health professional.[5] Recent general practice data shows 10.8% of consultations involved the management of a mental health problem and depression is now the fourth commonest problem managed in general practice.[6]

In response to this situation mental illness was designated as a National Health Priority Area.[7] A National Mental Health Strategy was established in 1992 and five year National Mental Health Plans have followed (currently third plan 2003-08).[8] In 2001 the Commonwealth government introduced the Better Outcomes in Mental Health Care (BOiMHC) initiative.[9]

2.2 Better Outcomes In Mental Health

The BOiMHC initiative was targeted at addressing the needs of patients and providers in general practice and primary care. It was funded for four years and in the 2005 Federal Budget a further four years of funding was provided. Its aim has been to improve the quality of mental health care delivered in general practice. The initiative has five components:[10]

1. Education and training for GPs
2. The 3 step mental health process
3. Focussed psychological strategies
4. Access to Allied Psychological Services
5. Access to psychiatrist support

There has been good uptake of the different components and evaluation to date is very positive.[11, 12] One of the most popular

components is the Access to Allied Psychological Services (ATAPS).

2.3 Access to Allied Psychological Services

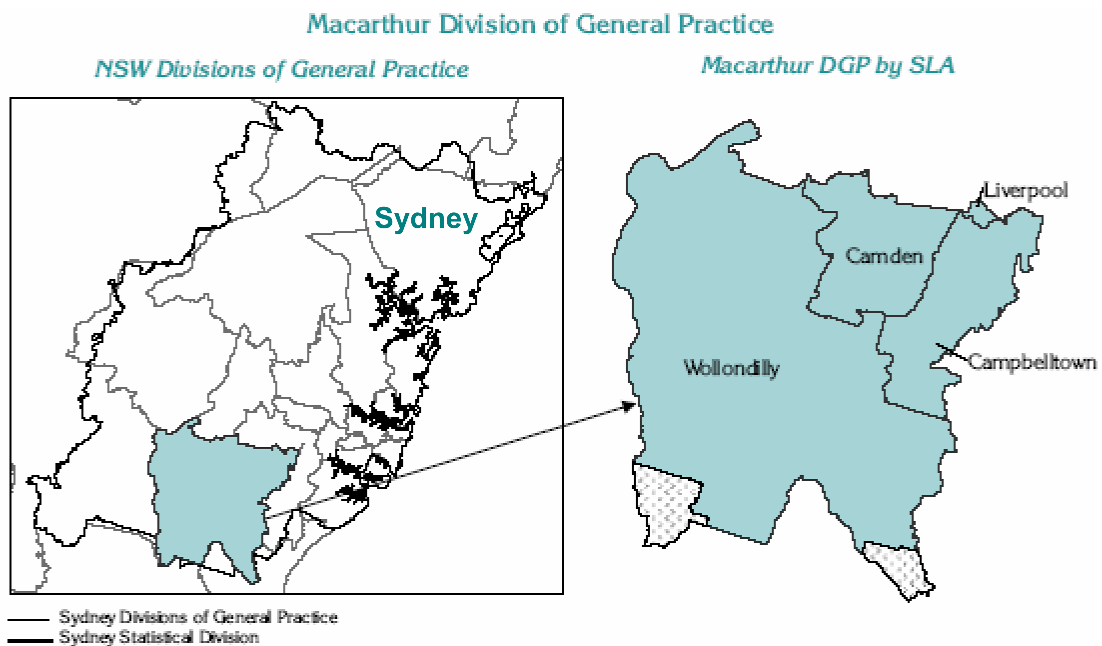
The ATAPS program, previously named the Access to Allied Health Services program, allows GPs to refer patients for time-limited focussed psychological treatments with allied health professionals. Funds are held by Divisions of General Practice who are able to establish program models to suit their local circumstances. The most important feature of these programs is that they provide access to psychological services at no or minimal cost to the patient. From a small number of pilot sites there are now 108 projects across Australia.

National evaluation work by the University of Melbourne[13] has shown the projects are popular with patients as well as health professionals. GPs have found it provides an affordable referral option for many of their patients with mental health problems and patients have shown good clinical improvement following treatment. In the first three years of operation 2,980 GPs referred 26,444 patients to a total of 1,040 allied health professionals.[14] In 2004, in the third round of projects, Macarthur Division of General Practice (MDGP) received funding to establish an ATAPS program.

3. Macarthur Division of General Practice

3.1 Macarthur Profile

MDGP is located south-west of the Sydney metropolitan area (see map) and includes the local government areas (LGA) of Campbelltown, Camden and Wollondilly. The population of this region was 226,026 at the last census with the majority of this being in the Campbelltown LGA and less population density in Camden and Wollondilly LGAs which are semi-rural.[15]



The region is characterised by a younger population profile when compared to national figures. There are higher proportions of children and young people and lower proportions of older people.(Table 1).

Table 1: Population proportions by age 2004[16]

Age group (years)	Macarthur Division %	Australia %
0-14	24.4	19.8
15-24	15.6	13.8
25-44	29.5	29.3
45-64	23.0	24.2
65-74	4.3	6.8
75-84	2.4	4.7
85+	0.7	1.5
Total	**100**	**100**

Over the last 15 years the region has shown steady growth, greater than that experienced by the Sydney region.[16] Many new housing estates have been established in the Campbelltown area which attract families with young children.

There is a significant Aboriginal and Torres Strait Islander (ATSI) population, predominantly in the Campbelltown LGA which has an ATSI population (2.5%) above the state average (1.9%).[15] Relative to parts of south-west Sydney there is a smaller proportion of the population born overseas (21.4%). This is a predominantly English speaking area with almost 80% of the population speaking only English at home. The commonest languages other than English spoken include: Arabic, Spanish, Tagalog, Chinese languages, Samoan and Italian.[16,17]

The main industries of employment in the MDGP are wholesale and retail trade, manufacturing and education, health and community services.[17] The region has an unemployment rate (6.7%) which is above the state average (6.0%) and the socio-economic index for the area (SEIFA) shows a variation between LGAs. Campbelltown LGA is below the national average SEIFA score while the Camden and Wollondilly LGAs are above.[16]

Data from the National Health survey show that a higher proportion of the adult population in the MDGP report high levels of psychological distress compared to national rates.[16] Similarly a higher number report their health as only fair or poor. Again there is regional variation with the Campbelltown LGA estimated to have relatively greater numbers of mental and behavioural disorders than the rest of the region.[16]

3.2 Division activities

The MDGP was established in 1993 and became an incorporated body the following year. It currently has 176 GP members. There are an

estimated 34 other GPs who practice in the region but are not members. Over half of the practices are solo GPs (55), there are two corporate practices and the rest work in small to large practices (34). The full-time equivalent GP to population ratio is 1:1458 which is above the Australian average (1:1403).[16] The Macarthur region is currently experiencing a GP workforce shortage like many parts of Australia.

The Division provides a range of services to its members to support them in the provision of clinical services. This includes continuing medical education, assistance with clinical services via various targeted programs, practice support for accreditation, computerisation etc and links with local health services.

Programs which the Division is currently running in conjunction with local health services include: the Diabetes and Metabolic management program, Antenatal Shared Care, Macarthur GP After Hours Service, Immunisation support and Quality use of Medicines.[18] In the area of mental health the Division has established its ATAPS program, which more recently has included a focus on ATSI youth and adolescents in conjunction with Tharawal, the local Aboriginal Medical Service.

4. ATAPS Program MDGP

4.1 Program Outline

The MDGP received funding in August 2004 to establish an ATAPS program. A program officer commenced in October 2004 and the first referrals were received in February 2005. Since then the program has been receiving on average 40 referrals per month.

The model developed in the MDGP involves the Division contracting private psychologists to provide clinical services. Psychologists are paid $100/hour. GPs as per the requirements of the BOiMHC initiative need to have completed Familiarisation and Level 1 training and work in an accredited practice in order to be eligible to participate in the program. GPs are able to claim a Service Incentive Payment (SIP) for the 3 step mental health process.

The Division provides a comprehensive information package to both GPs and Allied health providers who are involved which outlines the process of referral and treatment and the administrative requirements. Flowcharts outlining the process are in Appendices 1 and 2.

In summary the process involves:

1. GP identifies patient who would benefit from psychological treatments
2. Mental health assessment and care plan completed (Appendix 3), including K10 score (Appendix 9). Patient consent obtained (Appendix 4).
3. GP sends referral (assessment plan and score) to psychologist
4. Psychologist contacts MDGP to obtain unique patient ID which confirms funding of sessions
5. Patient attends 6 sessions with psychologist. Psychologist completes DASS42 score (Appendix 10) pre and post treatment and provides progress report to GP (Appendix 5). De-identified data regarding demographics, session treatments and DASS 42 scores provided to Division (Appendix 6).
6. Patient reviewed by GP after 6 sessions (Appendix 7). K10 score administered again. If further sessions deemed necessary patient re-referred back to psychologist for another 6 sessions (Appendix 8). SIP payment can be claimed after this review.

When the program was first established GPs were required to ring the Division to obtain the ID number and confirm funding. Following meetings and feedback in late 2005 this was changed so that GPs no longer have to do this. Obtaining the ID number is essential so that the Division can track patient numbers, work within the fixed budget, and confirm payment for psychologists.

4.2 Steering Committee

The MDGP established a Steering Committee to provide guidance for the program. This committee comprises three GPs, the SSWAHS mental health liaison officer, the Division project officer and a community & carer representative. The group meets quarterly.

4.3 Project Participation

Table 2 shows the participation of health providers and the number of patient referrals since establishment of the ATAPS program.

Table 2 : Program Numbers

Feb 2005 – May 31 2006	**N**
GPs completed Level 1 training	35
Referring GPs	23
Treating psychologists	15
Patient referrals	316
Average referrals per month	40

4.4 Budget

Due to strong demand for the service the Division was forced to cease accepting referrals for a period of a few months in order to stay within the annual budget of the program. The program stopped accepting referrals between 1 December 2005 and 13 March 2006. Since recommencing the demand remains strong and there are concerns about insufficient funding for the 2006-07 year.

5. Evaluation

The MDGP contracted the University of New South Wales to evaluate its ATAPS program. This local evaluation will contribute to the national evaluation being conducted by the University of Melbourne. The Division also maintains the minimum data set required in a de-identified form.

5.1 Aim

The aim of this evaluation was to examine the impact of the ATAPS program on the treatment of mental health problems in the Macarthur region.

5.2 Objectives

The objectives of the evaluation were:

- To describe the demographics and reason for referral of patients participating in the program.
- To examine the change in severity of mental health problems using the K10[19] and DASS42 scores[20] (both validated psychological scores) before and after the series of psychological treatment sessions.
- To examine patient, GP and psychologist satisfaction with the program.

5.3 Data Collection

The data collected in order to conduct this evaluation was from a mixture of sources. Patient demographics, reasons for referral and psychological scores (K10 and DASS42) were received in a de-identified form from the Division's minimum data set. Patient satisfaction and GP and psychologist satisfaction data was obtained from semi-structured questionnaires. The details of these methods and the results are presented in the following sections.

5.4 Ethics

The SSWAHS Research Ethics Committee approved this evaluation as a quality assurance project (approval no QA2005/004).

6. Demographics of the Participating Patients

6.1 Method of Data Collection

During 2005-06 the 23 general practitioners in the MDGP who participated in the ATAPS program referred 316 patients. Patient demographic data was collected by the GPs and psychologists and this information was sent to the Division by the psychologists. The Division project officer extracted the data which was then sent to the evaluators in a de-identified form. SPSS v14.0 was used to analyse the data.

6.2 Results

Of the 316 patients referred during 2005-06, 65.5 % (n=207) were female. The mean age of the patients was 35.1 years (SD=16.2, range=77 [3-80]). Table 3 shows the age distribution of the patients.

Table 3: Age distribution of participating patients

Age group	Frequency	Percent
< 30 years	122	38.6
30-50 years	141	44.6
>50 years	53	16.8
Total	316	100.0

Almost all the patients spoke English at home (96.2%) and 11.7 % (n=37) were of ATSI origin.

Patients who resided in the Campbelltown and Minto areas accounted for the highest numbers of referrals. Table 4 shows the places of residence of all patients referred.

The vast majority of patients lived with family and friends (n=262, 82.9 %) and only 42 (13.3 %) lived on their own. The GPs classified 60.8 % (n=192) of those referred as low income earners. The education levels of the patients are shown in Table 5.

Table 4: Patient's place of residence

Area (based on postcodes)	Frequency	Percent
Campbelltown Area	92	29.1
Minto Area	61	19.3
Others	45	14.2
Eaglevale Area	34	10.8
Camden Area	33	10.4
Ingleburn Area	24	7.6
Narellan Area	20	6.3
Missing	7	2.2
Total	316	100.0

Table 5: Education levels of participating patients

Level of education attained	Frequency	Percent
Primary or below	39	12.3
Secondary: Year 10	134	42.4
Secondary: Year 11	15	4.7
Secondary: Year 12	43	13.6
Tertiary	60	19.0
Missing	25	7.9
Total	316	100.0

7. Clinical Diagnosis and Clinical Outcomes of the Participating Patients

7.1 Method of Data Collection

GPs when completing the mental health assessment form at the initial consultation were required to indicate the clinical condition(s) or diagnosis of the patient for which they were referring them to the psychologist. This data was extracted from the Division database and sent to the evaluator in a de-identified form.

To quantify the mental health status of the patient, GPs requested the patient to fill in the K10 measure (Appendix 9) at both the assessment and review stage, following 6 and/or 12 sessions with the psychologist. The pre and post K10 scores for each of the patients were collected from the Division database in a de-identified form.

The clinical psychologists completed DASS42 scores (Appendix 10) at the first and again at the 6th and/or 12th visit to assess the progress of the patients. Patient pre and post DASS42 scores were collected from the Division database in a de-identified form for the evaluators.

7.2 Results

The mental health disorders patients were most commonly suffering from were depression and anxiety and to a lesser extent alcohol and drug disorders. Table 6 summarises the diagnoses of the 316 patients referred. Some patients had multiple disorders.

Table 6: Diagnoses of participating patients.

Diagnosis	Number of patients
Depression	194
Anxiety	139
Alcohol & Drug Disorder	14
Depression+Anxiety	88
Depression+Alcohol & Drug Disorder	10
Anxiety+Alcohol & Drug Disorder	6
Depression+Anxiety+Alcohol & Drug Disorder	5

One patient had a psychotic disorder and two patients had an unexplained somatic disorder. Sixty patients had a diagnosis of “other mental health disorder” and these included conditions such as eating disorder (n=1), grief (n=1), adjustment disorder (n=1) and attention deficit hyperactivity disorder (n=1). The majority (n=49) in this group did not have a specific diagnosis attributed by the GP but had been referred for treatment under the category “Psychologist’s discretion”.

Pre-treatment K10 scores were available for 249 patients and post-treatment scores for only 28 patients. Post-treatment K10 scores were

unavailable for most patients because either the GPs did not record the scores or the patient did not attend for a review visit with the GP.

Analysis of the pre and post K10 scores showed a significant improvement in patients' mental health status as shown in Tables 7 and 8.

Table 7: Pre and Post K10 scores statistics

	Pre K10 Score	Post K 10 Score
N	249	28
Mean	30.9	21.6
Median	32.0	22.0
Mode	28	10[a]
Std. Deviation	9.7	9.8
Range	40	39
Minimum	10	3
Maximum	50	42

a Multiple modes exist. The smallest value is shown

Table 8 shows patient scores grouped into risk categories as defined by the Clinical Research Unit for Anxiety and Depression, School of Psychiatry, University of New South Wales.[21] Pre-treatment almost half of the total group (45.9 %) of 316 patients had scores indicating high levels of psychological distress. Of the small number of patients for whom post-treatment scores were available the proportion with high levels of distress had dropped relative to medium levels of distress.

Table 8: K10 scores & level of anxiety & depressive disorder by proportion of patients

K10 Score & Level of anxiety & depressive disorder	**Pre-treatment** (n=249)	**Post-treatment** (n=28)
10-15 Low or no risk	15 (4.7%)	10 (3.2%)
16-29 Medium risk	89 (28.2%)	12 (3.8%)
30-50 High risk	145 (45.9%)	6 (1.9%)

A *paired t-test* of patient scores where both pre and post K10 scores were available (n=27) indicated that the improvement shown by patients following completion of the psychologist sessions was statistically significant (t_{26}=3.6, p<0.001; mean difference = 6.7, 95% CI: 2.9 to 10.5).

Pre treatment DASS42 scores were available for 215 patients and post treatment scores for 82 patients. Scores were not available for the other patients because they had either not attended the 6th and/or 12th psychologist session or the psychologist did not administer the score. Analysis of the DASS42 scores (Tables 9, 10, 11, 12) shows patients' mental health status improved following treatment.

Table 9: Pre and post DASS42 scores statistics

	Depression Score		**Anxiety Score**		**Stress Score**	
	Pre	Post	Pre	Post	Pre	Post
N	215	82	215	82	215	82
Mean	21.8	11.4	16.3	9.5	23.6	14.9
Median	21.0	8.0	16.0	5.5	24.0	11.5
Mode	17[a]	2	2[a]	1[a]	18	11
Std deviation	12.4	10.7	10.3	9.7	10.4	10.9
Range	42	40	42	38	41	42
Minimum	0	0	0	0	1	0
Maximum	42	40	42	38	42	42

a. Multiple modes exist. The smallest value is shown

Analysis of the DASS42 scores prior to treatment showed almost fifty percent of all patients referred (n=316) had been suffering from moderate to extremely severe levels of depression, anxiety and stress. Post-treatment scores showed there was a reduction in the proportion of patients in the moderate to extremely severe categories (Tables 10, 11 12). This categorisation is based on the scoring system by Lovibond & Lovibond.[20]

Table 10: Level of Depression from Pre & Post DASS42 Scores by proportion of patients.

Category (Score)	**Pre-treatment** n=215	**Post-treatment** n=82
Normal (0-9)	45 (14.2%)	46 (14.6%)
Mild (10-13)	15 (4.7%)	5 (1.6%)
Moderate (14-20)	43 (13.6%)	14 (4.4%)

Severe (21-27)	31 (9.8%)	11 (3.5%)
Extremely severe (28+)	81 (25.6%)	6 (1.9%)

Table 11: Level of Anxiety from Pre & Post DASS42 Scores by proportion of patients.

Category (Score)	Pre-treatment n=215	Post-treatment n=82
Normal (0-7)	52 (16.5%)	46 (14.6%)
Mild (8-9)	15 (4.7%)	6 (1.9%)
Moderate (10-14)	33 (10.4%)	8 (2.5%)
Severe (15-19)	30 (9.5%)	10 (3.2%)
Extremely severe (20+)	85 (26.9%)	12 (3.8%)

Table 12: Level of Stress from Pre & Post DASS42 Scores by proportion of patients

Category (Score)	Pre-treatment n=215	Post-treatment n=82
Normal (0-14)	43 (13.6%)	49 (15.5%)
Mild (15-18)	30 (9.5%)	9 (2.8%)
Moderate (19-25)	42 (13.3%)	7 (2.2%)
Severe (26-33)	55 (17.4%)	11 (3.5%)
Extremely severe (34+)	45 (14.2%)	6 (1.9%)

A paired t test of the pre and post treatment depression, anxiety and stress scores (n=82) indicated that the improvement shown by patients after completing the psychologist sessions was statistically significant (for depression $t_{81}=6.5$, $p<0.001$; mean difference = 8.4, 95% CI: 5.8 to 11.0; for anxiety $t_{81}=6.3$, $p<0.001$; mean difference = 6.0, 95% CI: 4.1 to 7.9; and for stress $t_{81}=6.8$, $p<0.001$; mean difference = 7.2, 95% CI: 5.1 to 9.4).

8. Patient Satisfaction with the Program

8.1 Method of data collection

A patient satisfaction survey (Appendix 11) was developed by the evaluators. Patients were requested to complete the survey when they attended the 6th and/or 12th treatment session. These surveys were then collected by the Division and mailed to the evaluator. SPSS v14 was used for data entry and analysis.

8.2 Results

Satisfaction surveys were received from 17 patients. Surveys were not received from the vast majority of patients who participated because of administrative problems which resulted in surveys not being provided to patients at the final visit as well as some patients choosing not to complete the survey. Just over half of the patients (59%) surveyed had attended up to 6 sessions and the rest attended between 8 and 12 sessions.

8.2.1 Psychologist sessions

Of the 17 patients who returned surveys 13 (76%) were comfortable/very comfortable with consulting a psychologist for their problem and only two reported being uncomfortable. Many of the patients stated that what they liked best about the sessions was that it was a comfortable, non-judgemental situation which allowed them to be frank. Other aspects they liked are shown in Table 13.

Table 13: Aspects of psychologist sessions liked by the patients

Aspects of sessions liked most by patients	Frequency (%) n= 17
Comfortable,non-judgemental situation for discussion	7 (41.1)
Psychologist supportive and understanding	5 (29.4)
Provided strategies to deal with problems	2 (11.8)

In response to what they liked least about the sessions patient comments included: the difficulty experienced facing the issues and revealing their private thoughts, the time constraints of the sessions and one indicated travelling to the sessions. Just over half of the patients (n=9) felt they needed more treatment sessions with the psychologist and a further five were unsure.

8.2.2 Treatment by GP

Patients were asked how they came to explore mental health issues with their GP which subsequently led to the referral. For some of the patients (n=4) it was something that came up in the natural course of the consultation, for others (n=5) it was due to specific issues to do with anxiety, depression and life and work stressors. Some (n=4) mentioned there were relationship and family problems which prompted the discussion.

The patients surveyed commented that they found their GPs' treatment to be understanding (n=3), supportive (n=2) and helpful (n=2) for their mental health problems. The majority of the patients (n=11) had been prescribed medication for their mental health problem and of these eight were taking their medication at the time of the survey.

Sixteen patients indicated that their GP had explained why they were being referred to the psychologist. Almost all (n=15) felt their GP and the psychologist were working together to care for them.

8.2.3 Self-reported mental health

On a 10-point rating scale (1=worst and 10=best) patients were asked to rate their mental health status at the beginning and at the end of their participation in the program. Table 14 shows the results.

Table 14: Change in patient rating of pre and post treatment mental health

Difference	Frequency	Percent
No or insignificant improvement	1	5.9
Some improvement	9	52.9
Significant improvement	7	41.2
Total	17	100

Note: A difference of 0-2 before and after was regarded as no or insignificant improvement
A difference of 3-5 before and after was regarded as some improvement
A difference of >5 before and after was regarded as significant improvement

8.2.4 ATAPS Program

Patients were asked to express their agreement with several comments

regarding various aspects of the program as shown in Table 15. The proportions shown are the patients who agreed/completely agreed with the statement.

Some of the patients made a final comment about the program. These included that this was a valuable and helpful program, it helped them understand themselves better and it was affordable.

Table 15: Patients' responses to statements about program

Statement	n	% (n/17)
My GP was very supportive in helping me to explore my mental health problems.	17	100
I totally agreed with my GP when she/he proposed that that I should see a psychologist.	14	82.4
I did not like my GP sending my personal information to a third party (the Division) not involved in my care	5	29.4
I did not understand the purpose of seeing a psychologist	1	5.9
Getting to the psychologist's office was very difficult for me	3	17.6
Prior to this referral I did not know that a psychologist could help me deal with my problems	6	35.3
The sessions provided by the psychologist were well structured	17	100
The treatment provided by the psychologist helped me to deal with my problems	17	100
I am physically much better since I started the sessions with the psychologist	16	94.2
I feel much more capable of coping with my problems since referral to the psychologist	17	100
Overall, I was satisfied with the care that I received from the GP	17	100
Overall, I was satisfied with the care that I received from the psychologist	17	100
If I had the finances and were able to pay for such treatment, I would still attend	14	82.4
I would definitely recommend this program to others	16	94.2

9. GP satisfaction with the program

9.1 Method of data collection

In 2005-06, 23 GPs working in the Macarthur region participated in the program. A list of GPs who participated was obtained from the MDGP. A self-administered satisfaction questionnaire (Appendix 12), which included both closed and open-ended questions, was mailed out to all participating GPs. Two 2-weekly reminders followed the initial mail out. Eleven of the 23 GPs returned the questionnaires giving a response rate of 48%. The data was entered into and analysed in SPSS v14.

9.2 Results

9.2.1 Demographic characteristics

The characteristics of the GPs who completed the questionnaire are presented in Table 16.

Table 16: Demographic characteristics of surveyed GPs

Characteristic		n
Age (years)	≤40 41-50 ≥ 51	2 6 3
Gender	Male Female	6 5
Year of graduation	1970's 1980's 1990+	2 6 3
Place of graduation	Australia Overseas	8 3
Years in general practice	≤10 11-20 ≥21	4 3 4
Qualifications	FRACGP GP registrar VR	5 1 10
Hours worked per week	≤30 31-40 ≥ 41	1 6 4

The GPs surveyed all worked in group practices, and all but one worked in the Campbelltown, Ingelburn and Minto areas. One GP worked in Camden.

Seven of the GPs had attended mental health training in the last twelve months. The programs attended included those run by Beyond Blue, The Black Dog Institute, St John of God seminars, a psychotic illness workshop, cases studies in depression and small group learning activities.

9.2.2 GP opinion about BOiMHC initiative

All the surveyed GPs thought the BOiMHC initiative was the right approach to dealing with mental health care. Reasons given for this were that to date this was a neglected area and that BOiMHC was now working in the right direction and addressing some of the broader psychosocial needs of patients. It was also giving GPs a chance to up skill and helping them to structure mental health consultations. Three of the GPs indicated the access to psychologist services was why they felt BOiMHC was a good initiative and one commented that the affordability for patients was important.

9.2.3 3-step mental health process

The majority (n=7) of GPs experienced problems when using the 3-step mental health process. The problems cited were that there were too many visits in the process and they experienced difficulties in getting patients back for the third visit for review. Although not specific to the 3 step process they also mentioned that due to funding limitations of the program in the MDGP they were not able to refer and access the program at the time of the survey.

K10 and Mental Health assessment and review forms.

Ten of the GPs used the K10 and mental health assessment forms and the same number commented that they found these forms useful. One GP used the DASS21 score for assessment and review.

9.2.4 GP opinion about ATAPs program in MDGP

Referral Process

The majority of the GPs (n=7) thought the referral model, which in 2005 involved GPs referring to the psychologists and also having to obtain a patient ID from the Division, was the most appropriate. They felt

under this model they received good feedback from the psychologists (n=2) and it expedited the process. Two GPs expressed a preference for direct referral to the psychologist and not having to liase with the Division as well. One of these GPs raised concerns about patient privacy and one was unhappy with the amount of paperwork.

Session venue and session number

All GPs were happy with patients being seen at the psychologist's rooms. Seven of the GPs thought there should be flexibility in regard to the number of sessions the patient required. They felt patient needs varied, some requiring more than 12 sessions and others less than 6 sessions. The majority (n=10) felt the decision about number of treatment sessions should be made by both the GP and psychologist. One felt the psychologist alone should make the decision.

Communication between GPs and psychologists

Eight of the GPs felt the program had enhanced communication between themselves and the psychologists. They felt the feedback from the psychologists contributed to this and that there was improved discussion between the two providers. All 11 GPs found the progress reports from the psychologists after 6 or 12 sessions to be useful.

Clinical outcomes of patients and follow-up

The majority of GPs (n=10) were either satisfied or very satisfied with the patients' clinical outcomes. One GP was not sure. Most (n=9) agreed there should be long term follow-up of patients with five suggesting the GP should do this and three that it should be both the GP and psychologist. Two GPs felt that follow-up was not always necessary and the need for it should be determined by the GP and patient.

Overall satisfaction with program and suggestions for changes

Five GPs were "satisfied" overall with the program and three were "very satisfied". The main reasons cited were the access it provided to psychologists (n=8) and the affordability for patients (n=2). Aspects of the program the GPs liked least included: the paperwork (n=4), the referral process (n=1) which was felt to be cumbersome, the lack of flexibility to access more then 12 sessions (n=1), funding limitations (n=1) and the confusion about follow-up (n=1).

Seven of the GPs surveyed wanted to see changes to the program in the future. These included: streamlining the referral process and training of practice staff in arranging referrals (n=4), more funding (n=1) and the ability to refer patients to GPs who were interested in mental health (n=1).

Future of program and funding

Seven of the GPs expressed a strong desire for the program to continue and another three also wished it to be maintained. One GP indicated it should only continue if funding is available.

With regard to long-term funding the GPs preferences are shown in Table 17.

Table 17: GP preferences for future funding options

Funding source	No of GPs
Commonwealth &/or State government	5
Commonwealth &/or State government and patient payment	5
Psychologists given provider number	1

10. Psychologist Satisfaction with the Program

10.1 Method of data collection

In 2005-06 15 psychologists working in the Macarthur region participated in this program. A list of the psychologists who participated was obtained from the MDGP. A self-administered questionnaire (Appendix 13), including both closed and open-ended questions was mailed out to the psychologists. Two 2-weekly reminders followed the initial mail out. Seven of the 15 psychologists returned the questionnaires giving a response rate of 47%. SPSS v14.0 was used for data entry and analysis.

10.2 Results

10.2.1 Demographic characteristics

The demographic characteristics of the psychologists who returned the satisfaction survey are shown in Table 18.

Table 18: Demographic characteristics of surveyed psychologists

Characteristic		n
Age (years)	21-40 41-50	2 5
Gender	Female	7
Year of qualification in clinical psychology	Pre 2000 2000-2006	1 6
Years practicing clinical psychology	≤5 6-12	6 1
Hours worked per week	≤30 31-60	3 4

Three psychologists practiced in the Camden area, two in the Campbelltown area and one each in the Minto and Tahmoor districts. Only one of the psychologists was in solo practice, two were in group practice and the other four were located in a medical centre.

10.2.2 Psychologist opinion about the ATAPS program

All the surveyed psychologists thought the ATAPS program was the right approach to meeting the needs of patients with mental health problems. The main reason given for this was the affordability of the service for patients. They also mentioned that it provided a useful alternative to the overburdened public mental health service and provided quick access to a psychologist. They saw primary care as the appropriate first line treatment setting for mental health problems.

10.2.3 Psychologist opinion about ATAPS model in MDGP

Referral process

Four of the psychologists were happy with the model where GPs referred patients to the psychologist and also confirmed funding by obtaining the patient ID from the Division. The comment was made that this allowed referrals to be tracked and assists the Division as fundholder. Two expressed dissatisfaction with this model. One stated this system was confusing and another felt it added an extra step for obtaining treatment for patients who were often in distress.

Three psychologists expressed a preference for a different model. They suggested patient self-referral and cross referral within psychologists as well as matching client needs with psychologist experience.

Session venue and session number

The psychologists (n=6) were happy seeing patients in their own rooms. In response to whether they would be willing to see patients at the GP's surgery, four stated they would be willing and two that they would not want to consult at the GP's rooms. The reasons given were they needed to maintain their own rooms, they would need to be reimbursed for travel if they were to go the GP's rooms and it would take away time from billing hours in their practice.

The psychologists were split in regard to flexibility with the number of sessions. Three wanted more flexibility and three were satisfied with the current 6 and/or 12 sessions. The main reason cited for greater flexibility was that patient needs varied and more or less sessions may be required.

Communication between GPs and psychologists

Six of the psychologists indicated they were happy to provide the progress report to the GP following treatment sessions. Some of the psychologists (n=3) were satisfied with the level of

communication with the GP. They felt good communication was better for patient care and communication was improved if they were based in the same office as the GP. Two psychologists did not feel the program improved communication, they commented that they received little input or feedback from GPs and that the time constraints on GPs in practice resulted in poor communication.

Clinical outcomes of patients and follow-up

The majority of psychologists (n=5) were either satisfied or very satisfied with the clinical outcomes of the patients. One was not satisfied and felt there needed to be long term follow-up of patients. In response to the specific issue of follow-up, six of the psychologists felt there should be long-term follow-up of patients, of which half felt this should be a joint responsibility of both the psychologist and GP. The other three were evenly spread between nominating the GP, the psychologist or either for follow-up.

Overall satisfaction with the program and suggestions for changes

Overall three GPs were satisfied and one was very satisfied with the program. Two were unsure and one was not satisfied with the program. The aspects they liked most about the program were the fact that it was affordable for patients (n=3) and that it gave patients access to psychologists and another form of treatment (n=3). One psychologist liked that there were guidelines for the program.

What they liked least about the program was the paperwork (n=2), the payments were slow (n=2), the inability to obtain more sessions if required (n=1), that they did not receive enough referrals (n=1) and that the rules of the program changed (n=1).

In the general comments at the end of the survey one psychologist expressed some concern about referrals to unskilled psychologists and another felt there was good financial support for the patients and GPs in this program but not for the psychologists.

Four of the psychologists indicated they would like to see changes in the future. These included clearer guidelines (n=1) and better selection of psychologists for the program (n=1). One of the psychologists wanted changes to the referral process, more prompt payment and better GP collaboration.

Remuneration level

Six of the seven psychologists were happy with the remuneration level provided by the Division. Only one was unhappy and felt it was not adequate.

Future of program and funding

Six of the psychologists wanted the program to continue, two of them quite strongly agreeing with this. One psychologist only felt it should continue if there was ongoing funding.

The psychologists' preferences for long-term funding are shown in Table 19.

Table 19: Psychologist preferences for future funding options

Funding source	No of Psychologists
Commonwealth &/or State government	2
Commonwealth &/or State government and patient payment	4
Psychologists given provider number	1

11. Discussion

The ATAPS program in MDGP has been up and running since early 2005. It has proven popular with patients, GPs and psychologists and demand has been such that the program was required to stop accepting new referrals temporarily in order to remain within the budget. This evaluation examined program data as well as exploring patient and health provider satisfaction.

11.1 Patient demographics

Over the course of 2005-06 the ATAPS program in MDGP resulted in 316 patient referrals which was an excellent response for the first year of operation. Given the program ceased to accept referrals for a three month period for budgetary reasons the indications are that there is unmet demand for psychological services.

The majority of patients referred were female (65.5%), which is consistent with national mental health data showing women experience higher rates of mood and anxiety disorders and have higher rates of psychological distress than males.[3] National ATAPS data also shows that referrals for women are more common than men although female referrals were a little higher (>70%) nationally.[22] Similarly the mean age of patients nationally (38 years) was a bit higher than in MDGP (35.1 years).[14] This reflects the fact that a substantial proportion of patients referred in MDGP were under the age of 30 and the range extended to children as young as three years. MDGP does have a higher proportion of children and young people than the A ustralian average.[16]

Virtually all the patients spoke English at home (96.2%). It is worth noting that MDGP has a lower proportion of its population who have poor proficiency in English compared to the rest of Sydney (1.8% versus 4.8%).[16] ATAPS programs around the country show over 95% of referrals are for people whose first language is English so in this respect MDGP is no different. It does raise the question of whether people from culturally and linguistically diverse backgrounds are being catered for in MDGP, given 11.1% of the population were born in predominantly non-English speaking countries.[16] This issue is equally relevant to most ATAPS programs across the country.[23]

The Macarthur program did have a significantly greater proportion of referrals of patients of ATSI origin compared to the national ATAPS figures. (11.7% versus 1-2%).[22] This reflects the fact that the ATSI population in the Campbelltown region is above the national average. The MDGP has worked to address this need by actively engaging with the Aboriginal Medical Service in the region and encouraging referral to the program.

The GPs classified 60.8% of patients referred as low income earners. This is consistent with national ATAPS data[22] and shows

that GPs are trying to refer patients who would otherwise have problems accessing psychological services due to cost.

11.2 Clinical Outcomes

The commonest reasons for referral were by far depression and anxiety which is no surprise given how common these problems are in the community. Depression is now the fourth commonest problem managed in general practice.[6] These are also conditions which benefit from psychological treatments indicating appropriate referrals are being made. A small proportion of patients had drug and alcohol disorders.

Sixty patients (19%) were classified as having a diagnosis which was labelled as “other” and of this group the majority (n=49, 15.5%) did not have a diagnosis but had been referred for treatment at the psychologist’s discretion. This was an option unique to the program in MDGP. It highlights the fact that there is a need for psychological treatments for a wide range of patients, not just those with anxiety and depression.

K10 scores were collected by the GPs at the assessment and review stages. Unfortunately post treatment K10 scores were only available for 28 patients. This therefore limits the generalisability of the findings. Given there were pre-treatment scores for 249 patients it may be an issue of patients not returning for the review visit and therefore an inability to administer the K10 score. Pooled data show that the mean scores moved from high to medium levels of distress following treatment. Almost half of the patients had high levels of psychological distress and close to a third medium levels before treatment. The limited post-treatment scores indicate a shift in the relative proportions, with slightly fewer in the high risk category compared to the medium risk category. The improvement post-treatment was statistically significant.

DASS42 scores were collected by the psychologists before treatment and after the 6th and/or 12th session. Again the number of post treatment scores were limited although better than K10 scores. Pre and post treatment scores show improvement in mental health with a reduction in mean scores and a shift from severe levels of depression, anxiety and stress to milder levels. Statistical testing showed the changes were significant.

The improvement in clinical scores seen indicates that patients’ mental health is improving following the treatment sessions. The difficulty is knowing whether all of the improvement is attributable to the psychologist treatments alone. There is no control group for

comparison and there may be confounding factors however the findings strongly support that the program does have benefits for people. The findings in the MDGP resonate with the most recent national evaluation which found there were improvements in clinical outcomes when data was pooled from a number of programs.[22] What is not known is whether these improvements are sustained over time as currently there is no long-term follow-up of patients.

11.3 Patient satisfaction

Patient satisfaction data were obtained from only 17 patients out of the 316 who were referred. This was disappointing and partly due to some administrative problems. It therefore needs to be borne in mind that the comments which follow apply to a very small sample of the total cohort of patients. They may well reflect the experiences of the larger group but this cannot be assumed.

Overall the responses from the satisfaction questionnaires indicated that patients were happy with the program and felt it helped them with their problems and provided them with strategies to deal with their issues. They valued the opportunity to talk to someone who was non-judgemental and supportive and were satisfied with the treatment sessions provided by the psychologists.

There were some problem areas raised by patients. A number of patients felt there was a need to have more treatment sessions than they were able and a few felt the sessions were time constrained. The fact that they actually would have liked more sessions and/or time per session suggests that they are happy with the treatment. Not surprisingly some patients found the sessions somewhat confronting given they needed to talk about very personal issues with the psychologist.

Three patients found accessing the psychologist's rooms difficult. It would be useful to know if this was a more general problem and if so consider ways to provide alternative venues for treatment sessions.

The patients were also satisfied with the care they received from their GP in relation to their mental health problems and felt their GP and the psychologist were working as a team to care for them. It is also encouraging to see that patients understood why they were being referred to a psychologist, indicating they are being provided with appropriate information by their GP.

Of the patients surveyed all but one reported improvement in their mental health following the treatment which backs up the objective findings of the clinical psychological score outcomes. The limited satisfaction data from patients shows that the program is benefiting them and they value the treatment sessions. Interestingly only one patient specifically made a comment about the affordability of the

service. However many of them stated that they would be willing to pay for treatment if they had the finances.

11.4 GP and psychologist satisfaction

Almost fifty percent of the participating GPs and psychologists completed satisfaction questionnaires. This provided a good representation of their views. Similar to the patients, GPs and psychologists were happy with the program and valued this additional option for care of patients with mental health problems. Their feedback provides useful information for the MDGP in planning the ongoing operation of the program.

11.4.1 BOiMHC initiative and ATAPS program

GPs and psychologists alike felt the Commonwealth investment in primary mental health care services via the BOiMHC initiative was the right direction to take. The access to psychological services ATAPS provides for people who do not have the financial means to pay for private services is seen as its most important feature. GPs also commented that the initiative gave GPs an opportunity to up skill. It was positive to note that apart from Level 1 training many of the GPs had attended other continuing educations programs in mental health.

GPs experienced problems with the 3 step mental health process which is a key feature of the BOiMHC initiative. There were problems getting patients back for the third visit. This is a common experience for GPs nationally and the process has of course been modified by the Commonwealth so that only two visits are now necessary, one of which is planned. This may assist GPs although given the second visit still requires the patient to return for a planned review it needs to be seen whether this has a significant impact.

11.4.2 Program model

The majority of the GPs and psychologists surveyed were satisfied with the referral system as it existed in the beginning of the program where GPs made a referral to a psychologist and also had to liaise with the Division to obtain an ID number for the patient. The ID number confirmed the patient would be funded for the treatment sessions. A

few from both groups however were unhappy with this system; there were concerns about privacy issues, it was felt it complicated the system by adding an extra step and was confusing.

As outlined in the background MDGP modified the referral process in late 2005 in response to provider feedback. GPs are no longer required to liaise with the Division and it is the responsibility of the psychologist to obtain an ID number. From discussion with the Executive Director of the MDGP[24] this system appears to be working well now. At all times the GP has made the clinical referral direct to the psychologist. The Division from the outset has been keen to encourage GPs and psychologists to develop closer working relationships and felt this was an essential aspect of the working model. The most recent national evaluation has shown that direct referral models seem to be associated with better clinical outcomes for patients.[22]

Both GPs and psychologists felt that it was best for patients to see the psychologists in their rooms. There was reluctance on the part of some psychologists to consider seeing patients at the GP's rooms because it was felt this would impact adversely on their own private practice. Nationally programs vary in the location of the treatment sessions, in some programs psychologists do consult at the GP's rooms or even in an alternative location eg community health centre. The reluctance of some psychologists to consult in other locations is understandable although the advantages of having some flexibility is that it may assist those patients who have access difficulties and it can provide opportunities for enhanced communication between GPs and psychologists.[25]

Currently ATAPS programs provide a fixed number of sessions (6 or 12) with little flexibility. A number of GPs and psychologists felt patient needs can vary and an ability to have more or less sessions would be beneficial. Providing more than 12 sessions has budgetary implications and may then limit the total number of referrals which can be accepted. The Division as fundholder has to manage this tension and is limited by Commonwealth guidelines and the fixed budget for the program.

11.4.3 Clinical outcomes

The majority of health providers who returned questionnaires were satisfied with the clinical outcomes for their patients following treatment. There was also a general consensus that long-term follow-up would be useful. Currently ATAPS programs are unable to ascertain whether the positive outcomes patients are showing are maintained. Within the current budget there is no real capacity for MDGP and the participating health providers to provide planned follow up for these

patients six or twelve months following treatment.

11.4.4 Communication between GPs and psychologists

The progress reports provided by psychologists to GPs are valued by both parties. Some GPs and psychologists felt the program had contributed to better communication between themselves which was one of the aims of the Division in establishing this program. The written report was one factor contributing to this as was co-location.

On the other hand a few psychologists were not happy with the level of communication with GPs. They did not feel they received adequate input from the GPs, partly due to the GP's time pressures. Accessing GPs for clinical discussion about a patient is often difficult and perhaps consideration needs to be given to ways in which to facilitate the process. Possibilities may be using e-mail communication, GPs establishing the times when they are best contactable by phone and if there were a number of patients in common perhaps trying to organise a face to face meeting. Utilisation of case conferencing item numbers may be a possibility if there was a third health provider involved although confidentiality issues may make this difficult for mental health patients.

11.4.5 Administrative issues

Both GPs and psychologists were unhappy with the paperwork involved in the program. This is not an unexpected finding and applies equally to many programs in general practice and is consistent with ATAPS evaluation findings in other Divisions.[14, 25]

All but one of the psychologists surveyed were satisfied with the remuneration received. This is perhaps a little unusual as other Divisions with similar rates have found the psychologists do not feel the payment is adequate and are unhappy because other costs such as travel, professional development etc are not covered.[25] A few psychologists felt the payment process was slow and the Division may need to look at this.

11.4.6 Future of the program

There was general agreement that the program was of benefit and should continue to be funded. Ongoing Commonwealth government funding was seen as the main option with possibly patient co-payment. Medicare rebates for psychologists were nominated by two providers, one GP and one psychologist. The BOiMHC initiative received funding through to 2009 in last year's budget. In addition in the May 2006 budget further mental health funding was introduced including increased access to psychologists. It is still unclear exactly how this will operate and what implications this will have for Division ATAPS programs. The success of the ATAPS program in the MDGP shows there is clearly strong demand for psychological services in this region and supports its continuation.

11.4.7 Limitations of the evaluation

This evaluation provides as comprehensive a report as was possible within the limitations of the available data and cost. The relatively small sample of post-treatment psychological scores makes it difficult to definitively conclude that patients improved from the treatment although the indications are strong that they did. As previously mentioned the lack of a control group and long-term follow-up also limit the findings. With regard to the satisfaction data the very small number of patient questionnaires is a significant limitation. There was also no capacity within the evaluation budget to do any sort of economic analysis which may be useful for long term planning.

12. Conclusion

The ATAPS program in the MDGP is clearly well established in the area and has been well received by GPs and psychologists. It is providing a useful referral option for patients who would otherwise be unable to afford private psychology services. Patients appear to have benefited from the treatments and if limited satisfaction data is any indication they are in general happy with the program and what it has to offer. Given the poor response rate of patient satisfaction questionnaires for this evaluation, it would be useful for the MDGP if in future a greater sample of patients who complete the program are canvassed about their level of satisfaction.

GPs and psychologists were in the main positive about the program and supported its continuation. Some of them were unhappy with aspects of the program such as administrative arrangements, processing of psychologist payments and the levels of communication between GPs and psychologists. The Division may need to consider these issues in its ongoing planning. The program has helped develop relationships between the two groups which is always a challenge and this will no doubt be a continuing process.

The MDGP has ably established an ATAPS program which is running well and with strong demand for its services. It has been shown to be responsive to provider feedback to date as demonstrated by the modifications to the referral process. It would be useful if it could consider ways to improve the collection of post-treatment psychological scores for the minimum data set as these scores are invaluable in demonstrating the impact of the program. Although outside the scope of this evaluation it should be noted that the MDGP has shown itself to be responsible in managing its budget for this program, temporarily ceasing new referrals to remain in budget. Consequently the program continues to run with a steady flow of referrals into the 2006-07 year.

References

1. McLennan W. Mental health and well being: profile of adults, Australia 1997. Canberra: Australian Bureau of Statistics and Australian Government Publishing Service, 1998.
2. Mathers C, Vos T, Stevenson C. The burden of disease and injury in Australia 1999. Canberra: Australian Institute of Health and Welfare Canberra, 1999.
3. ABS 2006b. 2004-05 National Health Survey: summary of results, Australia ABS cat no 4715.0 Canberra ABS. Canberra: ABS.
4. Hall W, Lynskey M, Teeson M. What is comorbidity and why does it matter? *National Drug & Alcohol Research Centre* 2001.
5. Henderson S, Andrews G, Hall W. Australia's mental health: an overview of the general population survey. *Australian and New Zealand Journal of Psychiatry* 2000;34:197-205.
6. AIHW: Britt H, Miller GC, Knox S, et al. General Practice Activity in Australia 2004-05. AIHW cat no. GEP 16. Canberra: AIHW, 2005.
7. Department of Health and Ageing. National Health Priority Areas http://www.aihw.gov.au/nhpa/mentalhealth/index.cfm Accessed July 31 2006: DOHA, 2006.
8. Department of Health and Ageing. National Mental Health Plan 2003-08http://www.health.gov.au/internet/wcms/Publishing.nsf/Content/mental-pubs Accessed July 31 2006, 2006.
9. Commonwealth Department of Health and Ageing. Better Outcomes in Mental Health Care initiative www.health.gov.au, 2006. Accessed July 31 2006.
10. Hickie I, Groom G. Primary care-led mental health service reform: an outline of the Better Outcomes in Mental Health Care initiative. *Australasian Psychiatry* 2002;10(4):376-382.
11. Hickie IB, Pikis JE, Blashki GA, Groom GL, Davenport TA. General practitioners' response to depression and anxiety in the Australian community: a preliminary analysis. *Med J Aust* 2004;181(7):S15-S20.
12. Thomas JE, Jasper A, Rawlin M. Better Outcomes in Mental Health Care - a general practice perspective. *Australian Health Review* 2006;30(2):148-157.
13. Evaluating the Access to Allied Psychological Services. *Program Evaluation Unit, The University of Melbourne* *www.peu.unimelb.edu.au*. Accessed July 31 2006.
14. Kohn F, Morley B, Pirkis J, et al. Evaluating the Access to Allied Psychological Services Component of the Better Outcomes in Mental Health Care Program. Sixth Interim Evaluation Report. Progressive achievements over time.: The University of Melbourne, 2005.
15. 2001 Census. Australian Bureau of Statistics, 2001.
16. PHIDU (2005). Population Health profile of the Macarthur Division of General Practice. Population Profile Series: No 14. In: editor. Adelaide: Public Health Information Development Unit (PHIDU), 2005.
17. Macarthur Regional Organisation of Councils. Macarthur Community Profile http://www.id.com.au/macroc/commprofile/ Accessed July 31 2006. Sydney, 2006
18. Macarthur Division of General Practice. What are Divisions and what do they do? http://www.macdivgp.com.au/ Accessed July 31 2006, 2006.
19. Andrews G, Slade T. Interpreting scores on the Kessler population. *Australasian and New Zealand Journal of Public Health* 2001;25:494-497.
20. Lovibond SH, Lovibond PF. *Manual for the Depression Anxiety Stress Scales.* 2nd ed. Sydney: Psychology Foundation, 1995.

21. Clinical Research Unit for Anxiety and Depression www.crufad.com/cru_index.htm: Clinical Research Unit for Anxiety and Depression Accessed July 31 2006
22. Morley B, Pirkis J, Sanderson K, et al. Evaluating the Access to Allied Psychological Services Component of the Better Outcomes in Mental Health Care Program. Eighth Interim Evaluation Report. Consumer outcomes: The impact of different models of psychological service provision: Program Evaluation Unit, University of Melbourne, 2006.
23. Kohn F, Morley B, Pikis J, Blashki G, Burgess P. Evaluating the Access to Allied Health Services Component of the Better Outcomes in Mental Health Care initiative - Fourth Interim Evaluation Report: the University of Melbourne, 2005.
24. Personal communication Rene Pennock, Executive Director MDGP July 26 2006, 2006.
25. Vagholkar S, Hare L, Hasan I, et al. Better access to psychology services in primary mental health care: an evaluation. *Australian Health Review* 2006;30(2):195-202.

Appendix 1

MACARTHUR DIVISION OF GENERAL PRACTICE LTD
BETTER OUTCOMES IN MENTAL HEALTH

Flowchart for GPs

Step 1
GP undertake a clinical consultation.
Clinical decision made for entry into the BOMH Program.

Step 2
Mental Health Assessment Completed Consent form signed.
Normal consultation fee charged.

Step 3
GP completes Mental Health Plan.
GP discusses the treatment with the client.
Normal consultation fee charged.

Step 4
GP decides on appropriate psychologist and forwards a copy of the assessment plan, K10 to the treating Psychologist and provides the patient with the Psychologist details and the Patient Information brochure.

Step 5
Psychologist undertakes 6 psychological sessions as per the BOMH program funding arrangement.
After the 1st and 3rd session the Psychologist will provide the referred GP with a brief update on the Patient Progress Report.

Step 6
At the end of the 6th session by the Psychologist, the client is referred back to the GP for review and completion of the 3-Step Mental Health Plan Consultation charge C2574 or D2577.
After the 6th session the Psychologist will provide the referred GP with a update report.

Step 7
If an additional 6 sessions is required, GP re-refers to the treating Psychologist with a revised K10 and an ‘Authority for Additional 6 Sessions’ form faxed to the Psychologist.
It is then the responsibility of the Psychologist to ring the Division for approval prior to commencement of the next 6 sessions.

Step 8
Psychologist undertakes a further 6 psychological sessions as per the BOMH program funding arrangement.
After the 12th session the Psychologist will provide the referred GP with an updated Patient Progress Report.

Step 9
BOMH 3-Step Process is completed.

Appendix 2

MACARTHUR DIVISION OF GENERAL PRACTICE LTD
BETTER OUTCOMES IN MENTAL HEALTH
Flowchart for Psychologists

Step 1
GP has identified required psychological strategies.
Patient given information flyer on BOMH Program.

Step 2
Psychologist receives referral from the GP and rings Jennifer Weatherstone or Lyn Long at MDGP to receive approval & Patient ID#. Psychologist must provide patient initials, date of birth and who is the referring GP.

Step 3
After receiving approval from MDGP the psychologist arranges appointment with patient.

Step 4
Minimum dataset including pre-treatment DASS 42 & Patient ID# sent to MDGP with initial invoice for payment. Note: Signed Patient Progress Report must be sent to referring GP after sessions 1, 3 & 6.

Step 5
Psychologists continues with balance of 6 sessions and submits invoices to MDGP for payment for treatments 2 – 5.

Step 6
Patient asked to complete Patient Satisfaction Questionnaire. Psychologist completed Post Treatment DASS42 and sends final invoice to MDGP for payment.

Step 7
Patient progress report sent to GP with 6th session DASS 42 completed and client referred back to GP as part of the 3-Step Mental Health Plan.

Step 8
GP reviews client. Clinical decision made as to the appropriateness of referring the client for 6 additional psychological sessions. If no further sessions are required – program is completed. If further sessions required continue with Step 9 & 10.

Step 9
If additional sessions required by GP, an "Authority for Additional Sessions" must be completed by the GP. It is the responsibility of the Psychologist to ring the Division (as in Step 2) for approval prior to commencement of the next 6 sessions.

Step 10
Psychologist repeats Steps 3 – 7 inclusive.

Appendix 3

MENTAL HEALTH REFERRAL ASSESSMENT PLAN	
First Name: ______________________________	Assessment Date: _____ / _____ / _____
Last Name: ______________________________	Referral Date: _____ / _____ / _____
Address:	
	D.O.B.: _____ / _____ / _____
Ph: Wk:	Mobile:
Aboriginal or Torres Strait Islander: No ☐	Aboriginal ☐ TSI ☐ Both ☐

Consent form signed by patient (to share clinical notes): Yes ☐ No ☐

Service Providers:

GP Name: ______________________________

Allied Mental Health Provider: ______________________________

Compulsory – please tick (√) appropriate box

Language spoken at home: English ☐ Italian ☐ Greek ☐ Cantonese ☐ Mandarin ☐

Arabic ☐ Samoan ☐ Vietnamese ☐ Other: ______________________________

How well does the person speak English: Very well ☐ Well ☐ Not Well ☐ Not at all ☐

Does the person live alone: Yes ☐ No ☐ Unknown ☐

Is the person a low income earner: Yes ☐ No ☐ Unknown ☐

Highest education level completed:

Primary/Below ☐ Secondary Yr 10 ☐ Secondary Yr 11 ☐ Secondary Yr 12 ☐ Tertiary ☐

Primary care diagnostic category using ICD10:

Alcohol and drug use disorders ☐ Psychotic disorders ☐ Depression ☐ Anxiety disorders ☐

Unexplained somatic disorders ☐ Other ☐ Unknown ☐

Is the client receiving psychotropic medication: Yes ☐ No ☐ Unknown ☐

Allied Health Intervention Requested – please tick (√) appropriate box	**Allied Health Cognitive Behavioural Therapy (CBT) – please tick (√) appropriate box**
Diagnostic Assessment: : Yes ☐ No ☐	Behavioural Interventions: Yes ☐ No ☐
Psycho-Education: : Yes ☐ No ☐	Cognitive Interventions: Yes ☐ No ☐
Interpersonal Therapy: : Yes ☐ No ☐	Relaxation Strategies: Yes ☐ No ☐
Previous Mental Health Treatment? Yes ☐ No ☐	Skills Training: Yes ☐ No ☐
Psychologist's Discretion: Yes ☐ No ☐	Other CBT Interventions: Yes ☐ No ☐

Mental Health History / Treatment:
Physical History:

Mental Status Examination

Appearance & 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)	Judgment / Insight (Ability to make rational decisions)
Anxiety Symptoms (Physical & Emotional)	Orientation (Time / Place / Person)	Speech (Volume / Rate / Content)

Risk Assessment:

Problem / Issue	**Goal** (e.g. Reduce symptoms, improve functioning).	**Action/ Task** (e.g. Referral for Allied Health, or pharmacological treatment or engagement of family / other supports)
1.		
2.		
3.		

Better Outcomes in Mental Health

Macarthur Division of General Practice Ltd
PO Box 5919 Minto BC 2566

Patient Consent Form

I hereby consent to my Mental Health Assessment and Mental Health Care Plan being provided to my treating Allied Health Professional and a de-identified copy to be made available to the staff of the Macarthur Division of General Practice.

I understand that the Macarthur Division of General Practice will use the information provided as a means of assessing the services being provided under the Better Outcomes in Mental Health Program.

I understand that the Allied Health Professional who is nominated to provide the Focussed Psychological Interventions (FPS) under the program will retain a record of the sessions and that these will be provided as a report to my GP at the completion of the treatment.

I agree to complete an evaluation form at the end of treatment so that the Division can continue to improve the service to future clients. I also understand that agreeing to complete an evaluation does not remove my right to withdraw from the evaluation component should any circumstance arise that I feel prevents me from doing so.

Client's Signature: ______________________________ **Date:** ____ / ____ / ____

Doctor's Signature: ______________________________ **Date:** ____ / ____ / ____

Better Outcomes in Mental Health

Macarthur Division of General Practice
PO Box 5919 Minto BC 2566

Patient Progress Report

Referring GP: ____________________ Psychologist: ________

Patient Name: ____________________ ID No: _______

Patient's D.O.B: ____________________

Session No: ____________________ Date: _______

Psychologist Report Update:

DASS Scores:

Session No.	Session Date:	Attended?	Cancelled ?	D	A	S	Total	K10
1st	____/____/____	Yes / No	Yes / No					
3rd	____/____/____	Yes / No	Yes / No					
6th	____/____/____	Yes / No	Yes / No					
12th	____/____/____	Yes / No	Yes / No					

PATIENT CONSENT

I have attended Session No: ______ and give consent to share information with my GP.

Patient Signature: ___ Date: __

Notes:

____

____

____

____

____

Appendix 6

Better Outcomes in Mental Health

Macarthur Division of General Practice
PO Box 5919 Minto BC 2566

Psychologist Sessional Data and Client Information Form

Patient ID: _______________ Date of Birth: ____ / ____ / ____ Gender M / F

Consent Signed: Yes / No Referral Date: ____ / ____ / ____

GP Name: _______________ Pt. Postcode: ________ GP Postcode: ________

PLEASE CONTACT THE DIVISION FOR APPROVAL & ID NUMBER BEFORE THE CLIENT COMMENCES THE PROGRAM.

Please Circle Appropriate Response

Aboriginal or Torres Strait Islander: No Aboriginal Torres Strait Islander Both

Language spoken at home:

English Italian Greek Cantonese Mandarin Arabic

Samoan Vietnamese Other: ____

How well does the person speak English:

Very Well Well Not Well Not at all

Lives Alone: Yes No Unknown **Low income earner**: Yes No Unknown

Highest education level completed: Primary/below Secondary Years 7-9

Secondary Yr 10 Secondary Yr 11 Secondary Yr 12 Tertiary

Primary care diagnostic category using ICD10:

Alcohol and Drug Use Disorders Psychotic Disorders Depression

Anxiety Disorders Unexplained Somatic Disorders Other Unknown

Is the client receiving psychotropic medication?: Yes No Unknown

Previous Mental Health Treatment? Yes No Unknown

CBT Information:

Allied Health Intervention Requested Tick (√) appropriate box	**Allied Health Cognitive Behavioural Therapy (CBT) – Tick (√) appropriate box**
Diagnostic Assessment: : Yes / No	Behavioural Interventions: Yes / No
Psycho-Education: : Yes / No	Cognitive Interventions: Yes / No
Interpersonal Therapy: : Yes / No	Relaxation Strategies: Yes / No
Psychologist's Discretion: Yes / No	Skills Training: Yes / No
	Other CBT Interventions: Yes / No

Appendix 6

Interventional Data: **Psychologist:** ________________________ **Pt ID:** ________

Pre DAS Score: **Pre K10 Score**

D	A	S	Total

K10

Sessional Information

Session No.	Session Date	Attended	Duration	Payment	Co-Payment	Invoice No:
1	____ / ____ / ____	Yes / No				
2	____ / ____ / ____	Yes / No				
3	____ / ____ / ____	Yes / No				
4	____ / ____ / ____	Yes / No				
5	____ / ____ / ____	Yes / No				
6	____ / ____ / ____	Yes / No				

Post DAS Score: **Post K10 Score**

D	A	S	Total

K10

Progress Report Sent to GP Yes No **Date Sent:**____ / ____ / ____

Additional Sessions Required? Yes No **Authority Received?** Yes No

Additional Sessional Information

Session No.	Session Date	Attended	Duration	Payment	Co-Payment	Invoice No;
7	____ / ____ / ____	Yes / No				
8	____ / ____ / ____	Yes / No				
9	____ / ____ / ____	Yes / No				
10	____ / ____ / ____	Yes / No				
11	____ / ____ / ____	Yes / No				
12	____ / ____ / ____	Yes / No				

Post DAS Score: **Post K10 Score**

D	A	S	Total

K10

Appendix 7

MENTAL HEALTH PLAN AND REVIEW

Patient Name		**Date of Birth**	
		GP Name	
Date of Mental Health Plan		**Actual Date of Mental Health Review**	

Outcome Tool		**Result at Assessment**		**Result at Review**	

	GOAL	**ACTION / TASK**
Problem / Issue	**(eg. Reduce symptoms, improve functioning)**	**(eg. Referral for Allied Health, or pharmacological treatment, or engagement of family/other supports)**
1.		
2.		

Allied Health Referral Data			
Intervention Requested		**Cognitive Behavioural Therapy (CBT):**	
Diagnostic assessment	Yes ☐ No ☐	Behavioural interventions	Yes ☐ No ☐
Psycho-education	Yes ☐ No ☐	Cognitive interventions	Yes ☐ No ☐
Interpersonal Therapy	Yes ☐ No ☐	Relaxation strategies	Yes ☐ No ☐
Other (specify)		Skills training	Yes ☐ No ☐
		Other CBT interventions	Yes ☐ No ☐
		Consent form signed by patient (to share clinical notes)	Yes ☐ No ☐

Follow Up / Relapse Prevention Plan (if appropriate)

Emergency Care

Notes

Patient Education given	Yes ☐ No ☐	**Copy of MH plan given to patient**	Yes ☐ No ☐

I understand the above Mental Health Plan and agree to the outlined goals / actions	
Patient Signature	**GP Signature**

Proposed date for Mental Health Review (between 4 weeks – 6 months)	

Review (Progress on actions and tasks)

Appendix 8

Better Outcomes in Mental Health

Macarthur Division of General Practice
PO Box 5919 Minto BC 2566

AUTHORITY FOR ADDITIONAL PSYCHOLOGICAL SESSIONS

Dear

I hereby authorise a further 6 sessions of psychological treatment under the Better Outcomes in Mental Health initiative for:

Name: **Date of Birth:**

____ _____ / _____ / _____

ID#:

____

Post K10 Score after 6 sessions: __________

A second K10 form is required before the client is able to access additional sessions.

Signed: **Date:**

____ _____ / _____ / _____

Dr Name:

____

Please fax this authority back to the relevant Allied Health Professional.

K10

For all questions, please fill in the appropriate response circle.

The maximum score is 50
The minimum score is 10

In the past 4 weeks:	1 None of the time	2 A little of the time	3 Some of the time	4 Most of the time	5 All of the time
1. About how often did you feel tired out for no good reason	❍	❍	❍	❍	❍
2. About how often do you feel nervous	❍	❍	❍	❍	❍
3. About how often did you feel so nervous that nothing could calm you down	❍	❍	❍	❍	❍
4. About how often did you feel hopeless	❍	❍	❍	❍	❍
5. About how often did you feel restless or fidgety	❍	❍	❍	❍	❍
6. About how often did you feel so restless you could not sit still	❍	❍	❍	❍	❍
7. About how often did you feel depressed	❍	❍	❍	❍	❍
8. About how often did you feel that everything was an effort	❍	❍	❍	❍	❍
9. About how often did you feel so sad that nothing could cheer you up	❍	❍	❍	❍	❍
10. About how often did you feel worthless	❍	❍	❍	❍	❍

DASS

Name: *Date:*

Please read each statement and circle a number 0, 1, 2 or 3 which indicates how much the statement applied to you *over the past week*. There are no right or wrong answers. Do not spend too much time on any statement.

The rating scale is as follows:

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

1	I found myself getting upset by quite trivial things	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 just couldn't seem to get going	0	1	2	3
6	I tended to over-react to situations	0	1	2	3
7	I had a feeling of shakiness (eg, legs going to give way)	0	1	2	3
8	I found it difficult to relax	0	1	2	3
9	I found myself in situations that made me so anxious I was most relieved when they ended	0	1	2	3
10	I felt that I had nothing to look forward to	0	1	2	3
11	I found myself getting upset rather easily	0	1	2	3
12	I felt that I was using a lot of nervous energy	0	1	2	3
13	I felt sad and depressed	0	1	2	3
14	I found myself getting impatient when I was delayed in any way (eg, lifts, traffic lights, being kept waiting)	0	1	2	3
15	I had a feeling of faintness	0	1	2	3
16	I felt that I had lost interest in just about everything	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 perspired noticeably (eg, hands sweaty) in the absence of high temperatures or physical exertion	0	1	2	3
20	I felt scared without any good reason	0	1	2	3
21	I felt that life wasn't worthwhile	0	1	2	3

Reminder of rating scale:

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

22	I found it hard to wind down	0	1	2	3
23	I had difficulty in swallowing	0	1	2	3
24	I couldn't seem to get any enjoyment out of the things I did	0	1	2	3
25	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
26	I felt down-hearted and blue	0	1	2	3
27	I found that I was very irritable	0	1	2	3
28	I felt I was close to panic	0	1	2	3
29	I found it hard to calm down after something upset me	0	1	2	3
30	I feared that I would be "thrown" by some trivial but unfamiliar task	0	1	2	3
31	I was unable to become enthusiastic about anything	0	1	2	3
32	I found it difficult to tolerate interruptions to what I was doing	0	1	2	3
33	I was in a state of nervous tension	0	1	2	3
34	I felt I was pretty worthless	0	1	2	3
35	I was intolerant of anything that kept me from getting on with what I was doing	0	1	2	3
36	I felt terrified	0	1	2	3
37	I could see nothing in the future to be hopeful about	0	1	2	3
38	I felt that life was meaningless	0	1	2	3
39	I found myself getting agitated	0	1	2	3
40	I was worried about situations in which I might panic and make a fool of myself	0	1	2	3
41	I experienced trembling (eg, in the hands)	0	1	2	3
42	I found it difficult to work up the initiative to do things	0	1	2	3

Scoring the DASS:

	Depression	Anxiety	Stress
Normal	0 – 9	0 – 7	0 – 14
Mild	10 – 13	8 – 9	15 – 18
Moderate	14 – 20	10 – 14	19 – 25
Severe	21 – 27	15 – 19	26 – 33
Extremely Severe	28+	20+	34+

Appendix 11

Evaluation of Macarthur Better Mental Health Project

PATIENT SATISFACTION SURVEY

Q1. Date of completion of the survey:______ / ______ / 2005

Q2. How did you come to explore your mental health issues with your GP?

____

____

Q3. Did your GP prescribe you any medication for your mental health problems?

☐ Yes
☐ No
☐ Not sure

Q4. Are you currently taking this medication for your mental health problems?

☐ Yes
☐ No
☐ Not sure

Q5. Did the GP explain to you why you were being referred to a psychologist?

☐ Yes
☐ No
☐ Not sure

Q6. Did you feel that your GP and the Psychologist were working together to assist you?

☐ Yes
☐ No
☐ Not sure

Q7. Would you like to make any comments regarding the care that you received from your GP about your mental health problems?

____

____

Q8. How comfortable did you feel about consulting a Psychologist about your mental health problems? **(Please tick one response)**

☐ Very comfortable
☐ Comfortable
☐ Unsure
☐ Uncomfortable
☐ Very uncomfortable

Q9. What did you like most about the sessions with the Psychologist?

____

____

Q10. What did you like least about the sessions with the Psychologist?

____

____

Q11. How many sessions did you have with the Psychologist? _______________

Q12. Do you think that you require further treatment from the Psychologist?
- ☐ Yes
- ☐ No
- ☐ Not sure

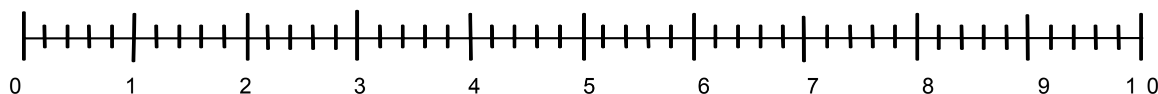
Q13. Would you like to make any comment regarding the care that you received from your Psychologist?

____

____

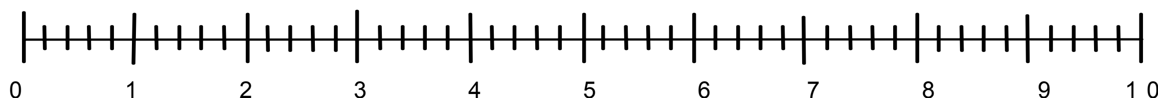
Q14a. Think about the week before you were referred by your GP to the Psychologist. How would you have rated rate your mental health in that week?

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



Q14b. How would you rate your overall mental health now after you have sessions 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 that you have felt:



Q15. **Could you please** rate **some aspects of the mental health care that you have received as listed below?** (Please circle one number or tick the box if you are not sure)

Aspect of Care	**I disagree completely**	***I disagree***	***I agree***	**I agree completely**	**Not sure (please tick)**
My GP was very supportive in helping me to explore my mental health problems.	**1**	**2**	**3**	**4**	☐
I totally agreed with my GP when she/he proposed that that I should see a psychologist.	**1**	**2**	**3**	**4**	☐
I did not like my GP sending my	**1**	**2**	**3**	**4**	☐

personal information to a third party (the Division) not involved in my care					
I did not understand the purpose of seeing a psychologist	1	2	3	4	☐
Getting to the psychologist's office was very difficult for me	1	2	3	4	☐
Prior to this referral I did not know that a psychologist could help me deal with my problems	1	2	3	4	☐
The sessions provided by the psychologist were well structured	1	2	3	4	☐
The treatment provided by the psychologist helped me to deal with my problems	1	2	3	4	☐
I am physically much better since I started the sessions with the psychologist	1	2	3	4	☐
I feel much more capable of coping with my problems since referral to the psychologist	1	2	3	4	☐
Overall, I was satisfied with the care that I received from the GP	1	2	3	4	☐
Overall, I was satisfied with the care that I received from the psychologist	1	2	3	4	☐
If I had the finances and were able to pay for such treatment, I would still attend	1	2	3	4	☐
I would definitely recommend this program to others	1	2	3	4	☐

Q16. Would you like to make any final comments about the program?______________________________

____

Thank you very much for completing this survey.

Please seal the survey in the attached envelope and hand it over to the psychologist receptionist.

UNSW

School of PUBLIC HEALTH & COMMUNITY MEDICINE

GP Id. __________

Evaluation of Macarthur Better Mental Health Project

PARTICIPANT GP SURVEY

1. Date of completion of survey ☐☐/☐☐/☐☐☐☐ (DD/MM/YYYY)

2. Your Age-group:
   - ☐ 21-30 years
   - ☐ 31-40 years
   - ☐ 41-50 years
   - ☐ 51-60 years
   - ☐ 61-70 years

3. Your Gender:
   - ☐ Male
   - ☐ Female

4. Year of graduation in medicine: ☐☐☐☐

5. Where did you obtain your primary medical degree?
   - ☐ Australia
   - ☐ Overseas, if overseas, please specify which country: ____________________________

6. How many years have you worked in general practice? ☐☐

7. Are you a
   - ☐ FRACGP?
   - ☐ GP-Registrar?
   - ☐ Neither?

8. Are you Vocationally Registered?
   - ☐ Yes
   - ☐ No

9. How many hours in a week do you work in general practice? ☐☐

10. What is the postcode of the main practice where you work? ☐☐☐☐

11. Is this practice a:
    - ☐ A solo practice?

☐ A group practice?

12. **Have you attended any postgraduate training on mental health (other than *familiarization training* for Better Outcomes in Mental Health initiative) within the past 12 months?**

☐ No
☐ Yes. Please specify, ____

13. Do you think the Better Outcomes in Mental Health initiative was the right approach towards addressing the needs in patient care for people with mental illness?

☐ Yes. Why do you think so? ____

☐ No. Why not? ____

14. Do you face any problems when you use the 3-Step Process for your mentally ill patients?

☐ No
☐ Yes, please specify: ____

____

15. Do you use K10 and Mental Health Assessment and Review Forms to assess and review your patients with mental health illness?

☐ Yes. Do you find those forms useful? ☐ Yes ☐ No

☐ No.Why not? ____

16a. Under the Division's *Access to Allied Health Services Program* you refer patients to the psychologist via the Division. Do you think this is the most appropriate model of referral?

☐ Yes. Why do you think so? ____

☐ No. Why not? ____

16b. Would you have preferred any other mode of referral?

☐ No
☐ Yes, please specify: ____

17. After the 6th session you were provided with a written progress report about your patients by the psychologist. Did you find those progress reports useful?

☐ Yes.
☐ No. Why not? ____

18. Your patients who had participated in this program were provided with counselling at the psychologists' rooms. Are you happy with this arrangement?

☐ Yes
☐ No. Why not? ____

19a. Under the current arrangements the patients either have 6 or 12 sessions with the psychologist. Do you think there should more flexibility in regards to the number of session?

☐ No
☐Yes. Why do you think so? ____

19b. Who do you think should determine the number of sessions required by a patient?

☐ GP should decide
☐ Psychologist should decide
☐ Both GP & psychologist
☐ Division's project officer should decide
☐ Patient should decide

20. Do you think the program has enhanced the level of communication between GPs and psychologists when it comes to patient care?

☐ No
☐Yes. Why do you think so? ____

____

21. How satisfied are you with the clinical outcome of your patients who participated in this program?

☐ Very satisfied
☐ Satisfied
☐ Not sure
☐ Not satisfied | Why not ? ____
☐ Not at all satisfied

22. For the patients who have completed participating in this program, do you think there should be provision for long-term periodic follow-up?

☐ Yes. Who should do this? ____

☐ No. Why not? ____

23a. Overall, how satisfied were you with the program?

☐ Very satisfied
☐ Satisfied
☐ Not sure
☐ Not satisfied
☐ Not at all satisfied

23b. What did you like most about the program? _______________________________________

____

23c. What did you like least about the program? _______________________________________

____

24. Would you like to see any aspect of the program changed in the future?

☐ No
☐Yes. What? ____

25. Currently, the program is funded by the Commonwealth on a year-to-year basis. Do you think this program should be in place for an indefinite period?

☐ Definitely yes
☐ Yes
☐ Not sure
☐ Only if funding is available
☐ The program isn't worth keeping

26. What do you think can be the long-term funding arrangement of the Access to Allied Health Services Program?

☐ Commonwealth &/or State Government should provide funding (1)
☐ Patients should pay for the psychologist session (2)
☐ A combination of (1) & (2)
☐ Psychologist should be provided with Medicare provider number

☐ Other, please specify: ____

27. Do you have any other comments? ____

____

Thank you for completing the Survey

Please return it to Iqbal Hasan, GP Unit Fairfield Hospital in the enclosed reply paid envelope.

Appendix 13

General Practice Unit

South Western Sydney Area Health Service
University of New South Wales

PO Box 5
Fairfield NSW 1860
Phone: (02)9616 8520
Fax: (02)9616 8400

THE UNIVERSITY OF
NEW SOUTH WALES

Psy ID:

Evaluation of Macarthur Better Mental Health Project

PARTICIPANT PSYCHOLOGIST SURVEY

1. Date of completion of survey ☐☐/☐☐/☐☐☐☐ (DD/MM/YYYY)

2. Your Age-group:
   - ☐ 21-30 years
   - ☐ 31-40 years
   - ☐ 41-50 years
   - ☐ 51-60 years
   - ☐ 61-70 years

3. Your Gender:
   - ☐ Male
   - ☐ Female

4. Year of psychologist qualification: ☐☐☐☐

5. How many years have you worked in clinical psychology? ☐☐

6. How many hours in a week do you work in clinical psychology? ☐☐

7. What is the postcode of your main practice? ☐☐☐☐

8. Nature of practice:
   - ☐ solo practice
   - ☐ group practice
   - ☐ within a medical centre

9. Do you think programs like "Access to Allied Health Services in Mental Health Program" are the right approach towards meeting the needs of patients with mental illness?

   ☐ Yes. Why do you think so? ______________________________

   ☐ No. Why not? ______________________________

10a. Under the Division's *Access to Allied Health Services Program* GPs refer patients to the psychologists via the Division. Do you think this is the most appropriate model of referral?

   ☐ Yes. Why do you think so? ______________________________

   ☐ No. Why not? ______________________________

10b. Would you have preferred any other mode of referral?

____

☐ No
☐Yes, please specify: ____

11. At the end of the 6th consultation you were required to provide GPs with a "progress report". Are you happy with this arrangement?

☐ Yes
☐ No. Why not? ____

12. Are you happy with the level of communication between GPs and psychologists when it comes to patient care?

☐ No. Why not? ____

☐Yes. Why do you think so? ____

13a. Under the current arrangement patients go to the psychologist rooms for their sessions. Are you happy with this arrangement?

☐ Yes
☐ No. Why not? ____

13b. If you are asked to provide sessions to patients in GP practices would you be willing to do so?

☐ Yes
☐ No. Why not? ____

14a. Under the current arrangements the patients either have 6 or 12 sessions with the psychologist. Do you think there should more flexibility in regards to the number of sessions?

☐ No
☐Yes. Why do you think so? ____

14b. Who do you think should determine the number of sessions required by a patient?

☐ GP should decide
☐ Psychologist should decide
☐ Both GP & psychologist
☐ Division's project officer should decide
☐ Patient should decide

15. How satisfied are you with the clinical outcome of your patients who participated in this program?

☐ Very satisfied
☐ Satisfied
☐ Not sure
☐ Not satisfied | Why not ? ____
☐ Not at all satisfied

15. For the patients who have completed participating in this program, do you think there should be provision for long-term periodic follow-up?

☐ Yes. Who should do this? ____

☐ No. Why not? ____

16a. Overall, how satisfied were you with the program?

☐ Very satisfied
☐ Satisfied
☐ Not sure
☐ Not satisfied
☐ Not at all satisfied

16b. What did you like most about the program? ____

16c. What did you like least about the program? ____

17. Would you like to see any aspect of the program changed in the future?

☐ No
☐ Yes. What? ____

18. Are you happy with the level of remuneration that you have received for participating in this program?

☐ Yes
☐ No. Why not? ____

19. Currently the program is funded by the Commonwealth on a year-to-year basis. Do you think this program should be in place for an indefinite period?

☐ Definitely yes
☐ Yes
☐ Not sure
☐ Only if funding is available
☐ The program isn't worth keeping

20. What do you think can be the long-term funding arrangement of the Access to Allied Health Services Program?

☐ Commonwealth &/or State Government should provide funding (1)
☐ Patients should pay for the psychologist session (2)
☐ A combination of (1) & (2)
☐ Psychologist should be provided with Medicare provider number

☐ Other, please specify: ____

21. Do you have any other comments? ____

____

Thank you for completing the Survey

Please return it to Iqbal Hasan, GP Unit Fairfield Hospital in the enclosed reply paid envelope.