Evaluation of an Australian Commonwealth Government initiative to improve consumer access to, and outcomes of, primary mental health care

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Introduction

Since the late 1990s, Australia has seen significant changes in the way in which mental health care is delivered in Australia. There has been increased recognition that disorders such as depression and anxiety are prevalent; the 1997 National Survey of Mental Health and Wellbeing showed that 6% of Australian adults (around 1,299,600) experience an affective disorder in a given 12-month period, and 10% (around 778,600) experience an anxiety disorder.[1] There has also been increased acknowledgement that many people with these high prevalence disorders receive no treatment or ineffective treatment,[2] and that those who do receive treatment tend to utilize GPs rather than providers like psychologists (29% utilise the former; 7% the latter[3]). GPs are well-placed to assess people with these disorders, who often present with a mix of physical and psychological symptoms, but they have traditionally been ill-equipped to provide effective psychological treatment (particularly non-pharmacological therapies[4]), citing barriers such as lack of training and time constraints.[5] By contrast, psychologists' training and mode of service delivery equips them well to provide treatment for common disorders such as depression and anxiety, but their services have tended to be out of the reach of many individuals, due to barriers of cost.

The Better Outcomes in Mental Health Care program aims to improve consumers' access to high quality primary mental health care, and was introduced in July 2001. The program has sought to achieve this by offering GPs training, systemic and professional support, and financial incentives via a number of interlocking components .[6]

Key among these components is the Access to Allied Psychological Services component, which supports GPs and allied health professionals (predominantly psychologists, but also social workers, mental health nurses, occupational therapists and Aboriginal and Torres Strait Islander health workers) to work together to provide optimal mental health care. Specifically, this component enables GPs to refer consumers to allied health professionals for six sessions of evidence-based mental health care, delivered in six time-limited sessions with an option of a further six sessions following a mental health review by the referring GP.

This collaborative approach to mental health care is occurring through 108 Access to Allied Psychological Services projects being conducted by Divisions of General Practice and funded, by the Commonwealth Department of Health and Ageing, in four funding rounds: 16 from June 2002 (Round 1 pilot projects); 13 from January 2003 (Round 1 supplementary projects); 39 from July 2003 (Round 2 projects); 33 from July 2004, one of which is no longer running (Round 3 projects); and seven from July 2005 (Round 4 projects).

Divisions are able to manage their Access to Allied Psychological Services projects as is appropriate for their area, within the guidelines stipulated by the Commonwealth Department of Health and Ageing. The flexibility afforded Divisions is recognition of the vast differences in communities around Australia. Divisions service both urban and rural and remote areas, all with unique socio demographic characteristics and with varying numbers in the local health workforce.

The Centre for Health Policy, Programs and Economics from the University of Melbourne, has been commissioned by the Commonwealth Department of Health and Ageing, to conduct the ongoing evaluation of the Access to Allied Psychological Services projects. Evaluation data has been drawn from various sources utilising a variety of methods, depending upon the information required. Local evaluation reports, purpose designed one-off surveys, interviews, focus groups and the minimum dataset have all been utilised at various times to provide in depth data regarding the Access to Allied Psychological Services projects. The current report aims to highlight the variability of the Access to Allied Psychological Services projects models of service delivery, from data collected in a purpose designed survey. In addition, data on the uptake of services, the profile of consumers and their outcomes will be presented, and the methodological issues discussed.

Methodology

Data Sources

Data for this report are drawn from two sources, a one off survey and the minimum dataset.

A one–off survey of models of service delivery was completed by each Division in 2005, which provided information regarding means of retaining Allied Health Professionals, where services are delivered, and how referrals are made. The survey data was analysed using simple descriptive analyses which focused on profiling the projects in terms of the models of service delivery being utilised.

Data from a web-based, purpose-designed minimum dataset, which captures de-identified, consumer-level and session-level information, was used to provide national and rural and urban results for the Access to Allied Psychological Services projects. The analysis period included the eighteen quarters from 1 July 2003 (when the minimum dataset was first 'rolled out') to 31 December 2007. Ninety-nine per cent of all projects submitted data to the minimum dataset during this period – 29 (100%) of the Round 1 projects, 39 (98%) of the Round 2 projects, 33 (100%) of the Round 3 projects and seven (100%) of the Round 4 projects. Data were extracted in January 2008 from the minimum dataset on the numbers of GPs and allied health professionals providing services through the projects, the number and profile of consumers accessing these services, the number and nature of these services, and the consumer outcomes associated with these services.

Data Analysis

The survey data were analysed using simple descriptive analyses which focused on profiling the projects in terms of the models of service delivery being utilised. These analyses are presented as simple percentages, as appropriate.

Simple frequencies and percentages are used to describe changes overtime in uptake and consumer and session profiles.

To examine consumer outcomes, a single-group pre-post measurement design across multiple projects was used in order to calculate effect sizes. This approach was chosen to cater for the naturalistic nature of the study, and the range of outcome measures being used within and across projects. Projects were included in the analysis if they had entered pairs of pre- and post-

treatment scores on a given outcome measure for at least five patients. Effect sizes (d) were chosen as the key metric as they present outcome in a standardised form to allow combination and comparison across multiple measures and studies, or in this case, projects. A detailed description of the method employed to calculate and interpret the resultant standardised effect sizes has been published elsewhere.[7]

Results and Discussion

Survey data on models of service delivery were available from 97 Access to Allied Psychological Services projects (95%): 14 Round 1 pilot projects (93%); 14 Round 1 supplementary projects (100%); 39 Round 2 projects (98%); and 30 Round 3 projects (91%). The survey showed that there is considerable variability across the Access to Allied Psychological Services projects with regard to the models of service delivery being implemented:

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

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

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

Participation in the projects by GPs and allied health professionals has changed over time

Between 1 July 2003 and 31 December 2007, 7,776 GPs referred consumers to 2,665 allied health professionals through the Access to Allied Psychological Services projects. The numbers of referring GPs rose steadily from 453 (257 rural; 196 urban) in the July-September 2003 quarter to a peak of 2,720 (1,073 rural; 1,647 urban) in the July-September 2006 quarter, reflecting the fact that existing projects became more established and additional projects became involved.

A similar pattern of participation by allied health professionals is evident, however less allied health providers are participating than GPs in general. In the July-September 2003 quarter, 135 (59 rural; 76 urban) provided services. This increased until the October-December 2006 quarter, during which 1,426 (407 rural; 1,019 urban) allied health professionals were providing services.

Since Access to Allied Psychological Services was introduced the number of referrals and sessions has continued to increase. Between 1 July 2003 and 31 December 2007, 100,854 consumers were referred to the Access to Allied Psychological Services

projects, 81,372 of whom took up the referrals provided. In total, 420,555 sessions of care were provided through the projects, making the average number of sessions provided to consumers 5.2. This average is likely to be an underestimate as projects differ in their ability to identify re-referrals because some have systems which preclude a consumer carrying the same identifier across referrals.

The profile of consumers has remained consistent over the life of the program. Around three quarters of all consumers are female, and their mean age is approximately 39 years. The majority (around two thirds) are on low incomes, as judged by their GP. About half have no previous history of mental health care. Of those for whom a diagnosis was made by the referring GP (n=82,526), most have been diagnosed with depression (75%) or anxiety disorders (57%). In the main, the profiles of rural and urban consumers are similar.

As with consumers, the profile of sessions has remained consistent over time. Sessions of 46-60 minutes have consistently been the most popular format over time, accounting for around four fifths of all sessions, and reflecting the complexity of care provided in these sessions. Almost all of these sessions have been delivered to individuals, rather than groups. The most common interventions provided through these sessions have been CBT-based cognitive and behavioural interventions, delivered in approximately 44% and 58% of sessions, respectively. These interventions are evidence-based, and widely regarded as appropriate for treating the types of high prevalence disorders with which consumers are presenting (see above profile of consumers). In the main, the profiles of sessions in rural and urban projects mirror the profile for all projects, but there are some nuances. For example, although the majority of both rural and urban sessions have consistently been 46-60 minutes in length, a slightly higher proportion of rural sessions have been under 45 minutes.

The only notable change over time with respect to the sessions of care provided has been in the charging of a co-payment. Figure 5 shows that in July-September 2003, only 6% of all sessions incurred a co-payment. Over time, a greater proportion of sessions did so. For example, one year later (July-September 2004), a co-payment was charged at 38% of sessions. As still more time elapsed, the pendulum swung back the other way, and the proportion of sessions associated with a co-payment reduced, though not quite to its previous low. In the July-September 2007 quarter, 13% of sessions involved a co-payment. The data on the pattern of co-payments in rural and urban projects show a similar pattern to the overall picture. However, the profile is more exaggerated for urban projects, with proportionally more sessions involving a co-payment at each point in time. Anecdotal evidence suggests that these fluctuations over time may represent an attempt to strike a balance between providing a free service to a limited number of people, and a low-cost service to a larger number of people.[8] They may also reflect the view that a small co-payment may encourage greater commitment to treatment on the part of the consumer.

More outcome data is becoming available from Access to Allied Psychological Services projects, the Divisions data were included in the analysis of consumer outcomes if they had supplied pre- and post-treatment scores on a given outcome measure for at least five consumers to the minimum dataset. Fifty-four projects had entered sufficient data to be included in the analysis, and provided data for a total of 11,823 consumers. This represents 50% of projects and 15% of treated consumers.

Pre- and post-treatment outcome scores were available from 15 different measures, the most frequently used are, the Kessler 10 (K-10), the Beck Anxiety Inventory (BAI), the Beck Depression Inventory (BDI), the Depression Anxiety Stress Scales 21 (DASS-

21), the Depression Anxiety Stress Scales 42 (DASS-42), the Health of the Nation Outcome Scales (HoNOS). Some projects use more than one outcome measure per consumer.

The mean pre- and post-treatment effect size, weighted for sample size, for consumers across projects is 1.02 (95% CI = 0.90 - 1.14). This indicates that, at worst, the effect size is 1.00. Based on Cohen's interpretation of effect size (small effect = 0.20, medium effect = 0.50, large effect = 0.80), this indicates a large positive effect.[9]

Forty three projects (80%) demonstrate positive 95% confidence intervals. Twenty three (43%) show large positive effects at worst, 12 (22%) show medium positive effects at worst, and 7 (13%) show small positive effects at worst. This interpretation is conservative, because the vast majority of point estimates are positive, and the projects with confidence intervals bounded by negative lower limits tend to be those with small sample sizes.

Conclusions

The collection of evaluation data has evolved overtime as have the Access to Allied Psychological Services projects. Initially the evaluation relied upon local reports from each project to compile the national reports, as more Divisions came on board the Minimum dataset was implement. In consultation with the participating Divisions and other stakeholders, the specific data to be collected were agreed upon, at this time Divisions were concerned with being over burdened by data collection so outcome measures were not included. This decision was not the preferred outcome for the evaluation team, but compromises were made to ensure that Divisions felt comfortable with the requirements of the evaluation. However, as more time elapsed Divisions and the Commonwealth Department of Health and Ageing saw the value in having consumer outcome measures added to the minimum dataset, to enable comments to be made about the success of the services being delivered. Therefore, outcome measures were added and to ensure that Divisions were able to run their projects flexibly, a number of measures were added rather than just one. From the perspective of the evaluation team it has continued to be important to be flexible and make adjustments to the data collection as much as possible when changes have been requested. The team has work hard in this area to maintain good relations with the Divisions as the service providers.

The Access to Allied Psychological Services projects are run across Australia, in light of this, the program guidelines have continued to be flexible to allow for appropriate service delivery in all areas. Specifically the services to be provided are stipulated by the Commonwealth Department of Health and Ageing, but they way each Division chooses to utilise their funds to provide those services, is a local decision. Therefore, the Divisions are operating under a range of service delivery models which have been adapted over time to best meet local needs. As a consequence, different models appear to be equally successful in different contexts at improving access to mental health care for consumers. The results from a later analysis, utilising the models of service delivery survey data and outcome measure data (added later to the minimum dataset), indicated that there is no significant difference in consumer outcomes related to the models of service delivery being utilised by Divisions. There is no evidence to suggest that Divisions should be modifying their locally-tailored models to adopt a more uniform approach.

The current report indicates that the Access to Allied Psychological Services projects have gained considerable momentum over time. Collectively, they are attracting far more GPs and allied health professionals and are providing greater access to high quality

mental health care than was the case originally. This is probably due both to an increase in the number of projects that are now in operation and to the streamlining of existing projects.

The projects are now well-established, and have passed their initial 'settling in' period, as is evidenced by the fact that the profile of consumers they are treating and the nature of sessions they are providing have both reached a point of consistency. The only notable variations in either relates to the issue of a co-payment, and the extent to which this has been charged has varied over time in line with projects' relative fluctuations in levels of funding.

Perhaps one of the reasons for the ongoing high demand for services provided through the Access to Allied Psychological Services is the fact that they are achieving positive consumer outcomes. There is good evidence that the projects are receiving positive results for consumers, in terms of alleviating symptoms, improving levels of functioning, and impacting on general wellbeing.

The Access to Allied Psychological Services projects appear to have become a crucial part of the mental health care landscape in Australia, and there continues to be a high demand for their services despite alternative avenues of service provision having been made available. They are reaching more and more people who may previously have had difficulty accessing services, and are providing high quality care in a consistent fashion. Most significantly, they are achieving their desired results. The evaluation has continued to evolve in order to report on the many aspects of the projects and the positive results they are achieving.

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