# Better access to psychology services in primary mental health care: an evaluation

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## Abstract

**Introduction:** The Access to Allied Psychological Services program was introduced as part of the Better Outcomes in Mental Health Care initiative in 2001–2002. Divisions of General Practice are funded to establish programs that allow GPs to refer patients for psychological treatments. The University of New South Wales evaluated programs run by the Southern Highlands and Illawarra Divisions of General Practice. This paper presents the findings of these evaluations.

**Method:** Both evaluations analysed process and patient outcomes. This was obtained from a combination of program data and qualitative satisfaction data.

**Results:** The two program models differed in the mechanism of retention of the psychologists and the method of referral of patients. Anxiety and depression were the main reasons for referral, and clinical data showed there was improvement in patient outcomes. Patients, GPs and psychologists expressed satisfaction with the programs.

**Discussion:** The Access to Allied Psychological Services programs in both Divisions have proven popular. Flexibility in the program structure allows Divisions to develop a model which suits their local circumstances. There is support for ongoing Commonwealth funding and the challenge is to find the most effective and financially sustainable model of delivery for psychological services in primary care.


**What is known about the topic?**

The capacity of general practitioners to provide care for patients with mental health problems, in particular access to private allied health care providers, has been limited by structural factors in the health system. The Access to Allied Psychological Services (ATAPS) program, introduced by the Commonwealth Government as part of the Better Outcomes in Mental Health Care initiative, has been established in 104 Australian Divisions of General Practice over the last 5 years.

**What does this paper add?**

Evaluation results from programs in two Divisions show the use of different approaches to referral and payment for psychologists, and patient demand for these services for a range of conditions. Good clinical outcomes for patients and positive health provider and patient satisfaction results provide support for continuation of these programs. The difficulty for Divisions is to manage demand within a fixed program budget.

**What are the implications?**

Ongoing delivery of the ATAPS program has the potential to meet the needs of patients with serious mental illness, and requires continued funding by the Commonwealth Government. Further research into long-term outcomes of patients in these programs and other models of care is warranted in order to determine the most effective models of care to fund. ◆

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MENTAL HEALTH CARE in Australia has tended to focus on specialist and hospital-based services for the more severely mentally ill, most often those with psychotic illness or severe depression. This has left those with the less severe but more common mood and anxiety disorders with poor access to specialist services, and they have thus relied on general practitioners.[1]

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The capacity of GPs to provide effective services for these patients has to date been limited by a number of factors including the fee-for-service structure, which acts as a disincentive to long consultations, inadequate training in managing mental health problems and limited access to allied mental health providers.[2] For patients in rural and regional Australia, access to psychiatrists is extremely limited due to a workforce misdistribution, with one psychiatrist per 6610 people in capital cities, one per 20 593 in large rural centres and one per 41 283 in other rural and remote centres,[3] and it is GPs who manage the majority of mental health problems.[1-4] Finally, cost acts as a barrier to patients accessing private services in both rural and urban areas.[2]

Against this background there has been considerable reform in mental health policy at a national level over the last decade. In broad terms it was acknowledged that a more integrated system of health care delivery was required in mental health and that primary care and general practice should play a key role.[5] This shift in policy led to the introduction of the Better Outcomes in Mental Health Care initiative (BOMHC) in the 2001–02 budget.[6] Its aim was to improve the quality of primary mental health care available in Australia. Initial data have shown good uptake of most components of the initiative.[7]

There are various models of integration between mental health services and general practice. These include consultation–liaison models, specialist clinics in general practice surgeries, community mental health teams and attached mental health professionals such as psychologists.[8] The Access to Allied Psychological Services (ATAPS) program, one component of the BOMHC initiative, most closely resembles this last model of integration. It provides GPs with the opportunity to refer patients for time-limited focused psychological treatments with allied health professionals such as psychologists and counsellors. Divisions of General Practice act as the fundholders and "purchase" the services of the allied health providers. Fifteen pilot sites were funded initially and this has now been extended to 104 programs.[9] Divisions are required to incorporate evaluation of the program into their operational plan, and these individual evaluations are being pooled in a national evaluation being coordinated by the University of Melbourne.[10]

The University of New South Wales School of Public Health and Community Medicine, under the auspices of two of its affiliated centres, the General Practice Unit (GP Unit), Sydney South West Area Health Service, and the Centre for Equity and Primary Health Research in Illawarra and Shoalhaven (CEPHRIS), was contracted to evaluate two ATAPS programs. The GP Unit conducted an evaluation for the Southern Highlands Division of General Practice (SHDGP)[11] and CEPHRIS evaluated the Illawarra Division of General Practice (IDGP) program.[12] The collection of a standard dataset enabled us to compare and contrast these two programs. This paper describes each divisional model, presents clinical outcomes of pooled patient data, examines provider and patient satisfaction with the programs and discusses the implications of these data for program sustainability and future policy.

## Methods

Each evaluation built on guidelines provided by the national evaluation group[10] and was adapted to suit the local program. They aimed to examine the impact of the ATAPS program in the respective Division and assessed both process and patient outcomes.

### *Process measures*

Data on number of GPs and allied health providers participating, number of referrals and sessions attended, GP satisfaction and allied health provider satisfaction were collected and analysed.

### *Patient measures*

Patient demographics, patient satisfaction and clinical outcomes were examined. Clinical outcomes were based on Kessler 10 (K10) and the Depression Anxiety Stress Scale (DASS), both validated psychological scores included in the National Mental Health Strategy.[13,14]

The data are a combination of quantitative and clinical data collected by the Divisions, GPs and psychologists as part of the operation of the program. Data were not always complete. Qualitative data were obtained from questionnaires and semi-

**1 Comparison of Division models and demographics 2004–2005**

| | | Division of General Practice | |
|---|---|---|---|
| | | **Illawarra** | **Southern Highlands** |
| **Division demographics** | Rural, Remote and Metropolitan Area (RRMA) Index* | RRMA 2 | RRMA 5 |
| | Population† | 257 000 | 40 840 |
| | Unemployment rate‡ | 9% | 5% |
| **General practitioner demographics** | No of GPs | 219 | 52 |
| | No of GPs who completed Level 1 training | 65 | 21 |
| | No of GPs who have referred patients | 30 | 14 |
| **Allied health professional demographics** | Means of retaining AHPs | Direct employment | Contracted private psychologists |
| | Type of allied health provider | Clinical psychologist | Psychologist/clinical psychologist |
| | No of AHPs involved | 9§ | 5 |
| | Location of consultation with AHP | GPs' rooms and other location | Own rooms |
| | Referral mechanism | Direct referral | Via Division |
| **Patient demographics** | No of patients referred | 250 | 148 |
| | No of sessions completed | | |
| | 1–6 | 199 | 111 |
| | 7–12 | 47 | 37 |
| | > 12 | 4 | 0 |
| | Sex | | |
| | Female | 71% | 75% |
| | Male | 29% | 25% |
| | Age | | |
| | < 30 years | 25.6% | 23.0% |
| | 30–49 years | 46.4% | 41.9% |
| | ⩾ 50 years | 28.0% | 31.1% |
| | Not known | 0 | 4.1% |
| | Language at home English | 90.8% | 100% |
| | Level of education | | |
| | Primary or below | 1.2% | 10.8% |
| | Secondary | 33.6% | 56.8% |
| | Tertiary | 8.0% | 7.4% |
| | Not known | 57.2% | 25.0% |

* Department of Primary Industries and Energy and Department of Human Services and Health. Rural, Remote and Metropolitan Zones Classification: 1991 Census edition. Canberra: Australian Government printing Service 1994.
† ABS Census 2001. ‡ Average NSW unemployment rate 7.2% (2002). § Includes 5 trainee psychologists.
AHP = allied health professional. ◆

**2 Reasons for patient referral to psychologists in each Division of General Practice**

| Diagnosis | Division of General Practice: Southern Highlands *n*=148 | Division of General Practice: Illawarra *n*=250 |
|---|---|---|
| Depression | 118 (79.7%) | 165 (66.0%) |
| Anxiety disorders | 82 (55.4%) | 128 (51.2%) |
| Alcohol and drug use disorder | 12 (8.1%) | 5 (2.0%) |
| Psychotic disorders | 1 (0.7%) | 5 (2.0%) |
| Unexplained somatic disorders | 2 (1.4%) | 1 (0.4%) |
| Other | 17 (11.5%) | 111 (44.4%) |
| Total* | 232 | 415 |

* Multiple responses were permitted. ◆

structured interviews specifically collected by the evaluators to assess satisfaction. The questionnaires and interview schedules used in both Divisions addressed similar issues. Results from the two evaluations have been combined for discussion in this paper.

## Results

### *Program models and demographics*

Each Division developed a model to suit their resources and to meet local objectives. Box 1 summarises the models, the participation rates of health providers and patients in both programs during 2004–2005 and the demographics of patients referred for treatment.

In the SHDGP private psychologists were contracted and remunerated based on time ($100/hour). GPs sent patient referrals to the Division, and the project officer allocated patients to psychologists, matching patient needs with the skills of the psychologists. This method was chosen as it was felt that the GPs were not always familiar with the psychologists and their areas of expertise. The IDGP model involved the Division employing psychologists as well as utilising psychologists in training. GPs made direct referrals to the psychologists.

### *Reasons for referral*

The predominant reasons for patient referral, based on diagnosis, were depression and anxiety (Box 2). There were a small number with drug and alcohol problems. Conditions which featured in the *other* category included bereavement, bipolar disorder, eating disorders and personality disorders. In the Illawarra this was a substantial proportion of the patient group due to the breadth of the referral criteria, the fact that only clinical psychologists were employed and the range of referrals made by GPs. Many of these patients had a combination of problems such as depression and anxiety or depression and an "other" disorder.

### *Clinical outcomes*

Clinical outcomes of patients were assessed by the referring GPs using K10[13] and by the psychologists using DASS42.[14] In the Illawarra, combined DASS scores were provided for the Division dataset. For the purposes of comparison with Southern Highlands, component depression, anxiety and stress scores could be extracted for 54 patients. K10 scores were only available in the Southern Highlands. Mean scores from both Divisions show that patients appeared to improve after completing their treatment sessions, in general from severe levels of depression and anxiety to normal or mild levels (Box 3). DASS42 and K10 scores in the SHDGP data were analysed with paired t-tests and all changes were statistically significant at $P<0.001$. Scores in the IDGP were not statistically tested.

### *Patient satisfaction*

Patients were asked to express their agreement with several comments regarding various aspects of the project as shown in Box 4. The proportions shown are the patients who agreed or completely agreed with the statement. The responses show that patients in general were very positive about the program and felt the treatment sessions benefited them.

### *GP and psychologist satisfaction*

Thirteen GPs and all participating psychologists in the SHDGP completed satisfaction questionnaires. In the IDGP twelve GPs and three of the psychologists completed questionnaires. The majority of GPs and psychologists in both Divisions expressed overall satisfaction with the program and indicated that

the best thing about this program was the access it provided to psychology services without any cost to the patients. There was also agreement that communication between GPs and psychologists improved as a consequence of using this program and that patients experienced positive clinical outcomes.

Most were happy with the mechanism of referral in their program. However some GPs and psychologists in the SHDGP would have preferred a direct referral mechanism for reasons of confidentiality and simpler administration. Other concerns raised by GPs in both Divisions were the need for less paperwork and simpler administration of the program. The psychologists were dissatisfied with the lack of flexibility of sessions available and raised concerns about the level of remuneration which they received, particularly that it did not meet recommended Australian Psychological Society levels and failed to cover administrative work and professional development costs.

Both groups were concerned about the sustainability of the program and suggested other possible sources of funding. These included patient copayments, state health funds and incorporation of the program into the Enhanced Primary Care item numbers. However, GPs and psychologists felt that realistically ongoing Commonwealth funding was essential for the program to continue. The psychologists were also in favour of Medicare provider numbers for psychologists and rebates for psychological services.

## Discussion

The two ATAPS programs demonstrate the flexibility of this initiative in that Divisions can tailor the service to suit local circumstances. The main differences between the two programs were the way in which psychologists were retained and the method of referral. The IDGP used a direct employment and referral method while SHDGP contracted private sector psychologists and GPs referred via the Division. The hourly fee paid to private psychologists by the SHDGP was about twice that paid to employed psychologists by the IDGP, but the IDGP had to cover overheads such as transport and office accommodation. The different mechanisms of retention of the psychologists impact on the cost of the program, and research is required into the cost-effectiveness of different models. Both appeared to have worked in their respective regions, although there was some dissatisfaction with the indirect referral method in the SHDGP. Given the variability across Australia in numbers of allied health professionals and preferences about how to practice, allowing Divisions freedom to develop their own models is an important feature of this program and should be maintained.

**3 Clinical outcomes: mean DASS 42 and K10 scores (2004–2005)**

| | | Division of General Practice | | | |
|---|---|---|---|---|---|
| | | Southern Highlands* | | Illawarra† | |
| Scoring system | | Score (Mean [SD]) | Rating‡ | Score (Mean [SD]) | Rating‡ |
| Depression (DASS) | Pre-treatment | 24.0 (11.0) | Severe | 21.5 (11.8) | Severe |
| | Post-treatment | 10.6 (8.9) | Mild | 8.3 (8.7) | Normal |
| Anxiety (DASS) | Pre-treatment | 16.5 (9.6) | Severe | 16.0 (10.3) | Severe |
| | Post-treatment | 7.3 (6.2) | Normal | 8.7 (7.4) | Mild |
| Stress (DASS) | Pre-treatment | 25.0 (9.4) | Moderate | 23.3 (9.8) | Moderate |
| | Post-treatment | 12.7 (8.5) | Normal | 13.3 (7.3) | Normal |
| K10 | Pre-treatment | 30.4 (7.1) | High risk | na | – |
| | Post-treatment | 23.1 (7.8) | Medium risk | na | – |

* In Southern Highlands pre and post DASS scores were available for 106 patients and pre and post K10 scores were available for 84 patients. † In Illawarra pre and post DASS scores were available for 54 patients and K10 scores were not available.
‡ See Appendix table for scoring system ranges. DASS = Depression Anxiety Stress Scale. K10 = Kessler 10 scale. ◆

The patient demographics from both programs were similar. The clients referred were predominantly female with the majority over the age of 30, peaking in the 30–49-years range. This is consistent with national mental health data which show that mental health disorders decrease with age, and women more commonly have anxiety and depressive disorders and account for the majority of mental health presentations in general practice while men are more likely to have a substance abuse disorder.[1,15] Almost all the patients referred spoke English at home. In the Illawarra, just over 9% of patients referred spoke a language other than English at home, compared with a population level of 15%.[16] This may indicate poorer access for people from non-English speaking backgrounds (although the numbers are small). In some Divisions, programs have been established to specifically provide psychological services for those who are culturally and linguistically diverse. (For example, Fairfield Division of General Practice, Transcultural Access to Allied Psychological Services Project. Information available by contacting the mental health program manager <www.fairdiv.org.au>)

By far the most common reasons for patient referral were anxiety and depression. The ATAPS program was designed to cater for this group of problems and this demonstrates that GPs are referring an appropriate range of patients. However, it is apparent that people with a range of other mental health problems are also seeking treatment and GPs are using the option of the ATAPS program to assist these people. In the SHDGP this was a relatively small number of referrals (11.5%) but in the Illawarra this group was significant (44%) because the program had a broader range of referral criteria.[17] Many of these patients also suffered from anxiety or depression. This raises issues about whether programs should limit their services to the anxiety/depression spectrum alone or encompass a wider range of diagnoses. Widening the range of psychological conditions in turn has implications for the capacity of the program to meet demand.

The clinical outcomes data show that many patients were suffering quite severe levels of psychological distress before treatment, possibly more than anticipated. Psychiatric opinion is that people who score over 30 on the K10 scale are likely to have a severe mental disorder.[18] The program data demonstrate that GPs are often dealing with patients who are experiencing quite disabling symptoms, making effective treatment all the more important. Post-treatment DASS42 and K10 mean scores from both programs indicate there was improvement to normal or mild levels of distress. The psychological

**4 Patient satisfaction responses**

| Statement | Number (%) of patients in the General Practice Division | |
|---|---|---|
| | Illawarra (n=38) | Southern Highlands (n=122) |
| My GP was very supportive in helping me to explore my mental health problems | 37 (97%) | 113 (92.6%) |
| I did not understand the purpose of attending sessions with a psychologist | 6 (16%) | 13 (10.6%) |
| Prior to this referral I did not know that a psychologist could help me deal with my problems | 10 (26%) | 31 (25.4%) |
| Getting to the psychologist's office was very difficult for me | 14 (37%) | 18 (14.8%) |
| The sessions provided by the psychologist were well structured | 36 (95%) | 108 (88.5%) |
| The treatment provided by the psychologist helped me to deal with my problems | 35 (92%) | 115 (94.3%) |
| I would definitely recommend this program to others | 36 (95%) | 118 (96.7%) |
| If I had the finances and was able to pay for such treatment, I would still attend | 28 (74%) | 98 (80.3%) |

treatments appear to be providing good outcomes for people. It is difficult to know if this improvement is due to the program alone, given there is no control group to compare with. Long-term outcomes are also uncertain as there is no capacity within programs for psychologists to follow up patients over an extended period.

Recent research based on consultations in each state and territory has shown that access to appropriate mental health services is a major concern for those with a mental disorder, their families and providers.[19] The most important outcome of this program in both Divisions has been improved access to psychological therapy at no cost. GPs and psychologists found that this has expanded the referral options available in their respective areas and meant that people unable to afford private psychology services now have access to these. Patients have also expressed satisfaction with the treatments provided and reported subjective improvement.

There is clearly demand for the type of service ATAPS provides, however, given the fixed budgets allocated to individual programs, the ability of both SHDGP and IDGP to meet future demand may be limited. Divisions across Australia are currently reporting they are running out of funding, resulting in long waiting lists and caps on services.[20] Participating GPs and psychologists in the IDGP and SHDGP clearly supported ongoing Commonwealth funding for this program. The future of ATAPS depends on how much funding the Commonwealth is prepared to provide. Other sources of funding and models of delivery such as computer-based self-help programs, which are currently being tested,[21] may need to be considered in order to meet demand and ensure long-term funding of ATAPS is sustainable.

Overall, GPs and psychologists in both Divisions were happy with the program, however there were some areas of dissatisfaction including administrative aspects of the program and levels of remuneration for the private psychologists. Findings from the national evaluation have shown that as the programs become well established and participants are more familiar with its operation many of these problems are addressed.[9] Remuneration levels, however, are dependent on program budgets, for which Divisions are reliant upon the Commonwealth, so there is less capacity to address this.

General practice and mental health services have until recent times been operating with little interaction. One of the aims of the BOMHC initiative was better integration and provision of mental health services in primary care.[5,6] GPs and psychologists involved with the ATAPS program did feel it enhanced their relationship and provided opportunities for greater communication. In the Illawarra, psychologists conducted some consultations at the GPs' surgeries and this factor probably contributed to enhanced communication. It is, however, questionable whether the program as it is currently structured actually results in an integrated team approach to management — it is predominantly a referral model of care.

The findings highlight some of the current issues surrounding the ATAPS program, however this paper reports on only two Divisions and the patient numbers were small, so it was not possible to draw strong conclusions. There were missing program data, which further limited the analysis. Patients who dropped out of treatment were not followed up, and there was no economic analysis in either Division due to the limited budget for evaluation.

## Implications for policy and research

The ATAPS program has proven to be a successful model of care in both the SHDGP and the IDGP, consistent with the findings of the national ATAPS evaluation.[9] The program has been a major development in primary mental health care in Australia and continued assessment of this model of care is important.

There is a need for long-term follow-up to see whether the improvements found by both patients and health care providers are maintained. Research into models with greater teamwork between GPs and psychologists and/or other mental health workers would be useful to determine the most effective model for primary care. The challenge for the health system and the Commonwealth is to ensure the programs are sustained and possibly expanded to meet a broader range of psychological conditions.

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## Competing interests

The authors declare that they have no competing interests.

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### Appendix DASS 42 and K10 scoring system interpretation of scores

| DASS 42 | Depression score | Anxiety score | Stress score |
|---|---|---|---|
| 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+ |

| K10 | Score level of anxiety/depression |
|---|---|
| Low risk | 10–15 |
| Medium risk | 16–29 |
| High risk | 30–50 |