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Utilisation of findings from the evaluation of a major primary mental health care initiative in Australia

Much has been written about evaluation utilisation from a theoretical perspective, but relatively less emphasis has been given to empirical studies that examine how the findings from given evaluations are utilised. The current study examined the nature and extent of utilisation of the findings from an ongoing evaluation of a key component of a major national primary mental health care initiative in Australia. The initiative is known as the Better Outcomes in Mental Health Care (BOiMHC) program, and the component involves 111 Access to Allied Psychological Services (ATAPS) projects, which provide mental health care to people who might otherwise have difficulty accessing such services. Nine reports have been produced during the evaluation of the ATAPS projects, and the current study explored how various stakeholders have used the first eight of these reports, via semi-structured interviews with 10 purposefully sampled respondents. The study revealed that the findings in the reports have been put to instrumental use (e.g. influencing decisions about program modification), conceptual use (e.g. furthering the knowledge base regarding the delivery of primary mental health care in general) and symbolic or legitimative use (e.g. confirming the original philosophy behind the BOiMHC program). Various reasons may account for this wide range of uses, including the fact that every effort has been made to identify all relevant stakeholders, garner their support for the evaluation from the outset, and communicate the evaluation findings to them in a relevant manner. The study provides empirical evidence that evaluation findings can be widely utilised, providing they are geared to the needs of the relevant stakeholders.

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Introduction

Over the last 25 years, many experts have debated theories of evaluation utilisation and considered particular factors that affect utilisation. There is an abundance of such theoretical literature, but relatively less empirical data from studies that have investigated utilisation practice. The current article uses a case study approach to describe the range and level of use of evaluation reports produced during the course of an evaluation of a large-scale primary mental health care initiative in Australia.

Utilisation-focused evaluation

According to Patton (1997), utilisation-focused evaluation is done with specific, intended uses for specific, intended primary users. Patton and various other authors have considered in detail both the nature (and types) of these uses, and the way in which primary users might best be engaged.

Different authors use different nomenclature, but essentially identify three main types of use to which evaluation findings may be put. 'Instrumental use' takes place when evaluation findings are acted on in specific and direct ways, such as when evaluation results are used to reshape a given health program. Sometimes this occurs in the context of 'judgement-oriented evaluations', where the findings of an evaluation are synthesised into a value statement or an assessment of merit or worth; sometimes it occurs in 'improvement-oriented evaluations', where information is used for 'reflection and innovation' (Leviton & Hughes 1981; Shadish, Cook & Leviton 1991; Stufflebeam 2001). 'Conceptual use' is more indirect, and relates to 'enlightenment' or generating knowledge in a given area (Larsen 1980; Owen & Rogers, 1999; Stufflebeam 2001; Weiss 1979). 'Symbolic use' or 'legitimative use' involves drawing on research to justify a position or action that has already been taken for another reason (Johnson 1998, Owen & Rogers 1999; Patton 1997; Weiss 1979), or to garner additional support for a program (The Oral History Project Team 2006).

In addition to these results-based types of use, the idea of 'process use' has also captured interest. This focuses on the way individuals learn about the program being evaluated and about the practice of evaluation, through their involvement in a given evaluation. Such learning may lead to changes in individuals' thoughts and behaviours, and, in turn, cultural and organisational changes (Patton 1997; Preskill, Zuckerman & Matthews 2003).

Kirkhart (2000) has challenged traditional thinking by proposing broadening the framework and moving from 'use' to 'influence'. This is based on the idea that influence has three interacting dimensions: source, time and intention. Kirkhart's ideas encompass earlier approaches by emphasising results-based and process-based use, but expand on these by asking the question, 'How and to what extent does an evaluation shape, affect and support and change persons and systems?' Henry and Mark (2003) take this one step further, considering the individual, interpersonal and collective mechanisms through which evaluation influence might occur, citing examples like justification, persuasion and policy diffusion.

Irrespective of the type of use or influence, an evaluation that is 'utilisation-minded' engages potential users (i.e. relevant stakeholders) at the outset (Patton 1997). King (2004) notes that 'it's the users, not the report, that play … a critical role in the evaluation process'. Engaging these users involves establishing who these users are and understanding the use to which they might put the findings. Different types of evaluation may be geared towards different users. So, for example, Patton (1997) suggests that although both funders and program staff/participants may make instrumental use of evaluation findings, funders may be more likely to do so in the context of making judgements, and staff may be more likely to do so in the context of making improvements.

Once potential users are identified, they must be 'brought on board' in order to maximise the likelihood of the findings of the evaluation being utilised (Innvaer et al. 2002). This involves garnering their support and giving them some 'ownership' of the process. It also involves establishing their needs and determining how best to meet them, particularly given that they (and the evaluation questions associated with them) may change during the course of the evaluation. Stufflebeam (2001) points out that the importance of deliberately involving stakeholders is to give 'them the information they need to fulfil their objectives' which involves 'gear[ing] a defensible program evaluation to the targeted users' evolving needs'. Utilisation-focused evaluation has been called 'active-reactive-adaptive and situationally responsive' because of the way it evolves through ongoing deliberation with stakeholders (Patton 1997).

Having said this, it must be acknowledged that there is some debate about the extent to which potential users of the evaluation should drive its design and implementation, which potential users should be involved, and what the nature of their involvement should be (Alkin & Christie 2005). Stufflebeam and Shinkfield (2007) warn that although the 'participant-oriented' approach of utilisation-focused evaluation is of prime importance, the evaluator must still adhere to professional standards with regard to designing the evaluation in the most methodologically rigorous manner and reporting relevant findings in an unbiased fashion. Stufflebeam and Shinkfield (2007) also note that this potential conflict may be exacerbated by the fact that identified stakeholders may not be representative of all users, and the process may give undue weight to the views of some. House (2003) calls for a distinction between depth and breadth of involvement, where depth refers to the level of stakeholder involvement and breadth refers to the number of stakeholders. It may be difficult to satisfy both, and the ultimate profile of stakeholder involvement may impact

on the extent and nature of the utilisation of the evaluation findings. Evaluators will be required to negotiate these roles and make choices about stakeholder involvement (House 2003; Patton 1997; Stufflebeam & Shinkfield 2007).

Communicating with relevant stakeholders in a meaningful and timely manner is also crucial in utilisation-focused evaluation. Patton (1997) summarises this by stating that getting the right information to the right people … [in the right way] … is the challenge. Owen and Rogers (1999) also flag the relationship between good communication and likelihood of utilisation, noting that stakeholders need to be informed about progress and given preliminary results as the evaluation moves through its various stages. Dibella (1990) also refers to this point in a more specific discussion about evaluation reports, explaining that these require careful crafting and personal promotion if their findings and recommendations are to be translated into agenda items for program managers.

Ideally, communication with stakeholders should not end once the final evaluation report is submitted, but rather should be continuous (King 2004). Posavac and Carey (2007) stress the importance of working with stakeholders once the evaluation is completed to implement changes, although they acknowledge that this may be easier for internal evaluators than external ones. Sonnichsen (2000) similarly argues for keeping the findings of an evaluation on stakeholders' agendas, since they may be of maximal relevance some time after they are first presented.

Familiarity with the context within which the evaluation is occurring is also important. In particular, is important to understand the relevant decision-making systems. Weiss (1979) argues that program and policy decisions are influenced by many factors, and that it is not realistic to expect any evaluation to be solely responsible for bringing about change. Even very good evaluations that have identified and involved all of the relevant players and have optimally communicated their findings will not influence decisions in the absence of other factors, such as political will and available resources.

Evaluation of the Access to Allied Psychological Services component of the Better Outcomes in Mental Health Care program

For the past five years, the Centre for Health Policy, Programs and Economics (formerly the Program Evaluation Unit) in the University of Melbourne's School of Population Health has been conducting an evaluation of a key component of a major Australian primary mental health care initiative known as the Better Outcomes in Mental Health Care (BOiMHC) program. Specifically, the evaluation has considered the processes, impacts and outcomes of the Access to Allied Psychological Services (ATAPS) component of the BOiMHC program. This component involves 111 projects being conducted across the country by Divisions of General Practice (local networks of general practitioners working in defined geographical areas). The projects have been funded in four funding rounds since June 2002. Through these projects, local general practitioners are able to refer their patients to allied health professionals (predominantly psychologists) for six to 12 free or low-cost sessions of evidence-based psychological care (i.e. interventions with proven efficacy, such as cognitive behavioural therapy). Both the BOiMHC program and its evaluation have been funded by the Australian Government Department of Health and Ageing.

The evaluation role of the Centre for Health Policy, Programs and Economics has involved synthesising information from a range of sources, with the overall aim of providing ongoing lessons about how the projects are going, who they are reaching, the type of care they are providing and whether specific models of service delivery seem to be effective in particular circumstances. The specific sources have included the projects' local project evaluation reports, a purpose-designed minimum dataset (a Web-based national database which captures de-identified socio-demographic, clinical, treatment and outcome information on patients), and several topic-specific surveys completed by Divisional project officers (one on models of service delivery, one on outcome measurement and one on demand management).

The above evaluation information has been presented in nine evaluation reports, which have drawn on different data sources and dealt with different evaluation questions (Kohn et al. 2005a; Kohn et al. 2005b; Morley et al. 2004; Morley et al. 2005; Morley et al. 2006a; Morley et al. 2006b; Naccarella et al. 2006; Pirkis et al. 2003; Pirkis et al. 2005). An overview of the reports is provided in Table 1, and a more detailed example of one of the reports is provided in Table 2.

The reports have been distributed to key stakeholders, including general practitioners and allied health professionals and their respective professional bodies (the Royal Australian College of General Practitioners and the Australian Medical Association in the case of the former and the Australian Psychological Society in the case of the latter), project officers responsible for the management of the ATAPS projects, staff of the Department of Health and Ageing, Divisional Liaison Officers (employed by state-based organisations to provide support to Divisions), and representatives from Australian Divisions of General Practice (the peak national body representing Divisions across Australia, now known as Australian General Practice Network). Hard and soft copies of each report have been made available via physical and electronic mail-outs. Each report has also been made available on the website of the Centre for Health Policy, Programs and Economics and on a website hosted by the Primary Mental Health Care Australian Resource Centre (an organisation based at Flinders University, which, until recently, provided knowledge

management, research, evaluation and information services to support Australian primary mental health care). The release of each report has been accompanied by a range of strategies designed to alert stakeholders to its contents, including presentations at relevant meetings and conferences and brief articles in several newsletters that are regularly accessed by stakeholders.

Focus of article

This article examines the nature and extent of utilisation of the first eight of the evaluation reports associated with the ATAPS projects. It considers the utilisation of these reports in aggregate, rather than individually, on the grounds that they represent iterative findings from an ongoing evaluation. It focuses on results-based utilisation, rather than process-based utilisation, because the latter would be more likely to be influenced by the evaluation as a whole, rather than the findings from individual reports. The article aims to provide a practical example of a utilisation-focused evaluation. It is hoped that this complements the theoretical literature on the topic, as well as providing some guidance for future evaluations as to how to maximise knowledge transfer.

Method adopted in current study

Ten respondents were purposely sampled and invited to take part in a semi-structured 30-minute interview. These respondents were selected on the basis that they provided broad representation from key stakeholder groups who might make use of the evaluation findings in different ways (e.g. to guide service delivery, to inform policy or funding decisions, to advise constituents about the ATAPS projects, etc.). They can be regarded as representing the groups that were the primary audiences for the evaluation. Many of these groups were represented on the evaluation advisory group that guided the evaluation design and implementation, although the individuals interviewed were not necessarily those who had sat on the evaluation advisory group.

Respondents comprised three Divisional project officers (selected in a manner that ensured coverage of projects that had been funded for different durations, guaranteeing a balance in terms of exposure to the evaluation reports), one Divisional Liaison Officer, and one representative from each of the following organisations: the Australian Medical Association, the Royal Australian College of General Practitioners, the Australian Psychological Society, Australian Divisions of General Practice, the Department of Health and Ageing, and the Primary Mental Health Care Australian Resource Centre.

During the course of the interviews, stakeholders were asked a series of open-ended questions to determine the extent and nature of use of the evaluation reports, and, where relevant, the impact of this use. The structure and nature of the questions varied slightly, depending on the given stakeholders' role, but all were asked:

- What have the evaluation reports been used for?
- What have the reports confirmed?
- What aspects of the reports have been the most useful?
- Have the reports affected any decisions or led to any changes?
- Was new knowledge regarding the program produced in the evaluation reports?

The questions were emailed to all stakeholders prior to the scheduled interview. One respondent preferred to provide a written response, but the remainder were interviewed by telephone. All interviews were audiotaped and transcribed.

A content analysis of the interviews was conducted. This involved identifying key themes as they related to each of the above research questions. The themes effectively became category labels, and interview segments or quotations were sorted by these category labels. In instances where separate themes within a category emerged, the categories were further divided into subcategories. Consistent with the approach of Morse and Field (1995), no attempt was made to count the frequency of responses as this was felt to be inappropriate for a qualitative study.

Results of study

What have the evaluation reports been used for?

The evaluation reports have been used for different purposes by different stakeholders. Most commonly, respondents commented on their usefulness in describing what was occurring in the field in terms of uptake (by general practitioners, allied health professionals and patients), models of service delivery and referral pathways. This descriptive information has been used by the Australian Division of General Practice and by state-based Divisional Liaison Officers to promote the program and update Divisional staff on the progress of the projects, and in turn by Divisional project officers to inform general practitioners and allied health professionals about patterns of service delivery. The latter feedback has been useful in informing these providers of their contribution to improved mental health service delivery.

In some instances, the reports have led to program modification. One respondent observed, *'It's been interesting … I certainly intend making more use of it in terms of the further development of our program'.* Other respondents commented that the reports enabled them to *'get a handle on things'* and *'modify aspects of their program'.* Yet another noted, *'[the reports have] … meant that they've been able to make positive adjustments to their model to make it work better as they've gone along. Fabulous'.*

The reports have not always led to program modification, however. Sometimes they have reassured project staff that their projects are

operating as well as or better than others across the nation, and have resulted in their maintaining the status quo. One respondent noted, for example, that it was useful to '*... see how the programs are operating nationally and where we sit within that. It's actually really good to read the national—you know, the outcomes and what's happening nationally—so that we can see we fit in with that ... It's affirming what we're doing*'.

The reports have also been used to assist with documentation related to the projects, including procedure manuals and media releases, being viewed as '*... an important reference for information about the projects*'. For example, the Australian Psychological Society has used the reports to prepare a procedure guidance manual (as yet unreleased) for allied health professionals involved in the ATAPS projects. The relevant respondent noted '*... we did include a lot of information from the evaluation reports in that. It helped us to be able to tell the allied health practitioners all the different models of care [and] which ones are the more popular ... They were particularly interested in the feedback from the field, ... the numbers of people that had been seen, the data showing the people that the program is intended for are actually the ones that are being reached ... That always helps to make people feel like they're being involved in something worthwhile*'.

The reports have been used by a variety of stakeholders for lobbying and advocacy purposes. In 2006, A$1.9 billion was set aside for mental health care reform, and submissions were made to relevant authorities regarding funding priorities. The Australian Divisions of General Practice and several of the professional bodies made submissions during this process, and drew on the reports to put forward a case for the value of the ATAPS projects, particularly in rural areas and areas of low socioeconomic status where there are few alternative mental health care providers.

Relatedly, the reports have been used to make a case for better evaluation of the other components of the BOiMHC program. There is an acknowledgement that evaluation efforts to date have focused heavily on the ATAPS component, and that this has occurred at the expense of evaluation of some of the other components. The reports have been cited at various forums designed to promote stronger evaluation of components related to general practitioners' direct delivery of mental health care.

What have the reports confirmed?

According to many respondents, the reports have confirmed that the original thinking behind the BOiMHC program in general and the ATAPS projects in particular is appropriate. As one respondent put it, '*I think they've confirmed that the original philosophy around the Better Outcomes initiative—collaborative care—works. I think ... it's confirming that [the] collaborative way of working is professionally satisfying for them [general practitioners and allied health professionals], but also it works for the patients*'.

At a more practical level, the reports have confirmed for individual Divisions that the approach they are taking is right. In the words of one respondent, '*From the Divisions' [point of] view, the reports have confirmed what we had thought we were doing, you know, was going really well and the reports have confirmed that ... It was having a sense of place in the broader scheme of things*'.

In addition, the reports have confirmed the '*... value of collecting data and information about programs for evaluation purposes at a local and national level*'.

What aspects of the evaluation reports have been the most useful?

Several respondents found it difficult to hone in on the 'most useful' aspects of the reports, making statements like, '*It's all helpful in terms of being a resource for me for the program ...*' They commented on the reports' overall quality instead, noting that this was '*rare*'. One respondent summed this up in the following way: '*There's a lot of things rolled out in the Divisions' network which don't have this calibre of evaluation attached to [them]. I think it's unique in that sense*'.

When they were asked to comment on what aspects of the reports had been the most useful, however, they tended to focus on specifics like the uptake data on the number of general practitioners and allied health professionals who had been involved, and the number of patients who had received care. The data that profiled the socio-demographic and clinical characteristics of patients and detailed the services provided to them was also viewed as useful. In particular, respondents valued the fact that the reports '*point[ed] out national trends*'.

Beyond this purely descriptive data, some respondents valued information on the projects' impacts. One respondent noted, for example, '*... there's been a degree of patient satisfaction that seems to have been picked up through a number of the reports*'.

Some respondents felt that more process-oriented information was of the greatest value, particularly for the purposes of lobbying for funding and/or justifying the program. Comparative information about different service delivery models was viewed as useful in this regard.

Still other respondents valued the interpretation of the data more than the data itself, commenting on the utility of the '*semantic analysis*'.

Have the reports affected any decisions or led to any changes?

As noted above, the reports have been viewed as a '*good resource*' and have been instrumental in guiding program modification (or non-modification) at a Divisional level. One project officer commented, '*It gave me a lot of ideas. I started jotting down ideas, certain things that can be changed or certain things that can be done. The reason it's a good resource is that it's about what's happening now all*

around us and we're part of, rather than something that was written about something that happened somewhere else'.

According to respondents, the reports have influenced decisions about the ATAPS program at other levels too. For example, the rulings about co-payments have been guided by the reports. The original contracts between the Department of Health and Ageing and Divisions left decisions about charging co-payments to the discretion of Divisions. The evaluation reports have documented the degree to which co-payments are charged and have demonstrated that the proportion of patients who are charged a co-payment has increased over time, as has the average co-payment amount. This has occurred in response to high levels of demand, and the reports have been useful in providing benchmarking information. As a direct consequence, the Department has capped the level of co-payment that can be charged: *'Yes. The Department has specified a maximum [patient] co-payment that can be charged through the projects ($30) in the new Funding Agreements with Divisions'.*

Respondents thought that the reports might have influenced changes at the policy level beyond the current ATAPS program. Specifically, they commented that the reports may have impacted on some of the mental health reforms that are currently under discussion in Australia. One respondent, for example, noted that *'… some of the decisions on the new [mental health] measures—particularly to expand the ATAPS type model or to put some additional funding into that model in rural and remote communities—have been supported by findings from the evaluation.'*

Was new knowledge regarding the program produced in the evaluation reports?

Respondents indicated that the evaluation reports had contributed to new knowledge in the field of primary mental health care. The literature in this area has tended to focus on the efficacy of interventions provided by psychologists alone, rather than by psychologists working in cooperation with other key primary care providers such as general practitioners. Respondents felt that the reports had furthered understanding about 'what works, for whom, and in what circumstances'.

In terms of 'what works', respondents were confident that the collaborative approach fostered through the ATAPS projects had demonstrated efficacy, on the basis of outcome data presented in the evaluation reports. Divisions are collecting outcome data via a range of measures—for example the Kessler-10 (K–10), the Depression Anxiety Stress Scales (DASS) and the Health of the Nation Outcome Scales (HoNOS). Data from these measures has been aggregated and presented in several of the evaluation reports. Various respondents commented on the fact that the reported outcome has demonstrated that such collaborative primary mental health care can result in positive changes in patients' mental health status and quality of life. One respondent commented, for example, that '*… it showed the K–10 scores … can change when you do this program and that's an interesting thing …'*

With respect to 'for whom', respondents praised the reports for providing data that profiled the patients who have been accessing care through the ATAPS projects. One respondent noted that this overall profile was useful because '*… we didn't really know who would use this service'.*

With regard to 'under what circumstances' respondents made reference to the wealth of information in the reports about the strengths and weaknesses of the different models of service delivery. The reports have generally concluded that different models are appropriate in different circumstances and that a 'one size fits all' approach would be unlikely to work. Respondents noted that this has contributed to knowledge about the processes that might facilitate good primary mental health care in other settings as well as in the current context.

Discussion

The findings from the evaluation of the ATAPS projects have been put to a range of results-based uses by different stakeholder groups. Most notably, the findings have been put to instrumental use (Leviton & Hughes 1981; Shadish, Cook & Leviton 1991; Stufflebeam 2001). For example, they have influenced decisions by Divisions to modify (or retain) the way in which individual projects are operating and decisions by the Department of Health and Ageing about contractual arrangements. The findings have also been put to conceptual use (Larsen 1980; Owen & Rogers 1999; Stufflebeam 2001; Weiss 1979), in the sense that they have contributed to the knowledge base regarding the delivery of primary mental health care. In addition, the findings have been put to symbolic or legitimative use (Johnson 1998; Owen & Rogers 1999; Patton 1997; The Oral History Project Team 2006; Weiss 1979). This latter form of use is sometimes viewed negatively, but in this case it has been valuable in confirming the original philosophy behind the BOiMHC program and underpinning lobbying and advocacy exercises related to Australia's new mental health reforms.

There may be several reasons for this wide range of uses. Every effort has been made to identify all relevant stakeholders (King 2004; Patton 1997), garner their support for the evaluation from the outset (Innvaer et al. 2002; Stufflebeam 2001), and communicate the evaluation findings to them in a relevant manner (Dibella 1990; King 2004; Owen & Rogers 1999; Patton 1997; Posvac & Carey 2007). The original evaluation framework was informed by an evaluation advisory group that comprised representatives from the majority of the stakeholder groups mentioned in the current article. In addition, ongoing dialogue has occurred between the evaluators and various stakeholders with regard to what information they require from the evaluation

(e.g. at the Divisions' request, the minimum dataset has been designed in such a way that reports can be automatically generated which allow individual projects to track their own progress). A tailored communication strategy has also been developed to ensure that key messages from the reports repeated in a variety of ways to a variety of audiences. So, for example, the evaluation team has worked closely with Divisional Liaison Officers and project officers to disseminate the findings of each report once it has been released. This has involved highlighting the findings and explaining their applications, via avenues like seminars and summary articles in newsletters.

The current study had several limitations, which should be acknowledged here. First, it was restricted to the views of 10 stakeholders, and it should be acknowledged that if a different 10 stakeholders had been interviewed, or if the total number of stakeholders was larger, different views about the utility of the evaluation reports might have been expressed. Having said this, the stakeholders were specifically selected because of their key role in each of the organisations they represented, and it would not have been possible or appropriate to randomly select them. It is also fair to say that the selected stakeholders were likely to have a comprehensive view of the way in which the evaluation reports have been 'rolled out' and their findings taken up. For this reason, the results of the current study are encouraging because they suggest that the evaluation work surrounding the ATAPS projects is having a significant impact 'on the ground'.

A second limitation is that the evaluation was perhaps unusual, in that it involved a series of evaluation reports that were produced over time and addressed different evaluation questions. Arguably, a more common evaluation scenario is a one-off evaluation involving a single final report. There might be a different level or type of utilisation from a series of reports than from a single report (e.g. a series of reports might build a receptive audience over time). It was beyond the scope of this study to distinguish between individual reports in terms of their level of utilisation, to determine whether they were used in different ways, or to establish whether the amount of time that had elapsed since their release had a bearing on their use. This has implications for the generalisability of the current utilisation findings.

A third limitation is that the interviews were restricted to 30 minutes and sought relatively high-level information, and some social desirability bias may have been introduced by the fact that they were conducted by the evaluators themselves. In an ideal world, longer interviews might have been conducted, more specific details about the utilisation of the findings in the evaluation reports might have been sought, and independent interviewers might have been employed. However, conducting longer interviews with the majority of the chosen respondents would not have been feasible, due to their competing time commitments. In addition, the evaluation team's own resource constraints precluded longer, more in-depth interviews and the employment of independent interviewers.

These limitations aside, the current study provides empirical evidence of the fact that evaluation findings can be widely utilised, providing they are geared to the needs of the relevant stakeholders. This should encourage evaluators who may sometimes feel that their work is commissioned purely to meet statutory requirements or contractual obligations, and is undervalued or even ignored.

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TABLE 1: SUMMARY OF FOCUS OF EVALUATION REPORTS

Report	Projects included	Data sources	Evaluation questions	Evaluation findings
First Interim Evaluation Report (Pirkis et al. 2003)	Round 1 pilot projects—Australia	Local evaluation reports	What models of service delivery are being used by the pilots? What is the uptake of the pilots? What are the advantages and disadvantages of the pilots?	The pilots are operating under a range of models. The models differ in terms of referral mechanisms (ranging from simple voucher systems to more complex brokerage systems), means of retaining allied health professionals (with most retaining them under some sort of contract and some employing them directly), and location of allied health professionals (with most providing services in GPs' rooms but some providing them in their own rooms or in a third location). The pilots have recruited 136 individual allied health professionals (primarily psychologists) and 10 agencies. In total, 387 GPs have referred 2036 patients to these allied health professionals. For participating GPs, advantages of the pilots included: savings in terms of time and cost and feedback from allied health professionals, and disadvantages included opportunity costs and other risks. For participating allied health professionals, advantages included an increased referral base and improved relationships with GPs, and disadvantages included payment anomalies and communication difficulties. For patients, advantages included access to psychological services although some noted barriers to attendance.
Second Interim Evaluation Report (Morley et al. 2004)	Round 1 pilot and supplementary projects—Australia	Local evaluation reports Minimum dataset	What models of service delivery are being used by the projects? What is the level of uptake of the projects? Who is accessing services through the projects? What services are patients receiving through the projects? What are the advantages and disadvantages of the projects?	A range of models is being used from simple voucher systems to more complex brokerage models. Intermediate models are now available which provide GPs with registers that profile allied health professionals in terms of their skills and competencies, thereby enabling GPs to make informed referral decisions. Depending on whether the minimum dataset of the local evaluation reports are used as the authoritative data source, the projects have involved between 710 and 926 GPs and between 160 and 229 allied health professionals. Together, these providers have enabled between 3476 and 3656 patients to access mental health care, which would otherwise have been out of their reach. The projects appear to be reaching the patients that they are supposed to be targeting—e.g. the majority are on low incomes (58%) and have not completed secondary education (56%), most have been diagnosed with depression (77%) and/or anxiety (55%) by their GP, and 40% have no previous history of specialist mental health care, indicating that their access may have previously been problematic. The number of sessions of therapy received to date is 8678. Most sessions tend to be close to an hour in length (71%), and involve individual treatment (99%). The most common interventions delivered through these sessions are cognitive and behavioural interventions (55% and 41%, respectively). In 76% of all sessions, no co-payment is required; in the remainder of sessions a co-payment of not more than $10 is charged. GPs and allied health professionals involved in projects are now feeling more satisfied that the initiative is viable and ongoing. Benefits observed by GPs include new skills and knowledge in the area of mental health and new referral options. Benefits observed by allied health professionals include improved relationships with GPs and an increased referral base. Patients are benefiting from ready access to high quality care. Despite these positives, GPs and allied health professionals have experienced some attitudinal and logistical barriers, and patients have experienced some inequities in referral.

Report	Projects included	Data sources	Evaluation questions	Evaluation findings
Third Interim Evaluation Report (Morley et al. 2005)	Round 1 pilot and supplementary projects, Round 2 projects, Round 3 projects—Victoria and Tasmania	Evaluation forum	Do models of service delivery differ from the conceptualisation outlined in the First and Second Interim Evaluation Reports? What are the benefits and barriers associated with the means of retaining allied health professionals? What are the benefits and barriers associated with the various locations from which allied health professionals deliver services? What are the benefits and barriers associated with the different referral mechanisms?	The evaluation forum provided support for the validity of the conceptualisation of the different models of service delivery put forward in the early evaluation reports. The major focus of the evaluation forum was in determining the benefits and barriers associated with the dimensions of the models. Often, the benefits of one model address barriers to another, and vice versa. So, for example, projects in which the allied health professionals operate from their own rooms may have benefits for GPs in terms of access to a range of providers, but may present problems associated with reduced opportunities to collaborate. Conversely, projects in which the allied health professionals are co-located with GPs may have advantages for GPs in terms of communication, collaboration and potential for knowledge transfer, but the downside may be a reduced range of providers to whom referrals can be made.
Fourth Interim Evaluation Report (Kohn et al. 2005a)	Round 1 pilot and supplementary projects, Round 2 projects—Australia	Local evaluation reports Minimum dataset	What models of service delivery are being used by the projects? What is the level of uptake of the projects? Who is accessing services through the projects? What services are patients receiving through the projects? What are the benefits and barriers associated with the projects? What lessons have been learned from the early experiences of the projects?	Earlier projects have been modified along the way in response to stakeholder concerns, and later projects have learnt lessons from their earlier counterparts. As a consequence, the projects are operating under a range of different models that vary in terms of means of retaining allied health professionals, location of allied health professionals, and referral mechanisms. The uptake of the Round 1 and 2 projects is high. Using the minimum dataset as the gold standard, 1771 GPs had referred 12 758 patients to 569 allied health professionals by 31 December 2004. There has been significant growth as time has passed and the Round 2 projects have developed. The Round 1 and 2 projects are reaching the patients that they are intended to target. For example, the majority (62%) are on low incomes, most have been diagnosed with depression (76%) and/or anxiety disorders (56%) by their GP, and 46% have no previous history of specialist mental health care, indicating that access may previously have been problematic for them. There are good indications that the Round 1 and 2 projects are providing free or low-cost evidence-based mental health care to patients through structured sessions. In total, the number of sessions of therapy received to date by patients in the Round 1 and 2 projects is 45 823. Most sessions (75%) are an hour in length, and 98% involve individual, rather than group-based, treatment. The most common interventions delivered through these sessions are CBT-based cognitive (61%) and behavioural (45%) interventions. In 63% of all sessions, patients are not required to contribute to the cost of care; in the remainder of cases they are asked to make a co-payment, usually of not more than $20. Participating GPs, allied health professionals and patients are very satisfied with the Round 1 and 2 projects. GPs, allied health professionals and patients appreciate upskilling opportunities, the increased referral base and the high quality of care, respectively. In spite of this, there have been some barriers to participation—e.g., paperwork hurdles for GPs, frustration at a perceived lack of decision-making power for allied health professionals, and equity issues for patients. Having said this, it should be noted that a number of the issues that were apparent in earlier local evaluation reports are less relevant in later ones—e.g., GPs are now less likely to experience confusion about how the projects operate, allied health professionals seem to be less concerned about the uncertainty of guaranteed work, and problems with inappropriate referrals have generally been 'ironed out'.

Report	Projects included	Data sources	Evaluation questions	Evaluation findings
Fifth Interim Evaluation Report (Pirkis et al. 2005)	Round 1 pilot and supplementary projects, Round 2 projects—Australia	Survey of models of service delivery	What is the profile of models of service delivery across the ATAPS projects? Are particular models associated with differential levels of patient access to services?	In 76% of projects, 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. All models appear to be performing equally well in terms of enabling patients to receive free (or low-cost), evidence-based mental health care.
Sixth Evaluation Report (Kohn et al. 2005b)	Round 1 pilot and supplementary projects, Round 2 projects, Round 3 projects—Australia	Local evaluation reports Minimum dataset	Has participation in the projects by GPs and allied health professionals changed over time? Have access to and the nature of mental health care for patients changed over time? Have the experiences of GPs, allied health professionals and patients changed over time? Are the projects achieving positive outcomes for patients?	2980 GPs have made referrals to 1040 allied health professionals since the projects began. There has been a dramatic increase in participation rates by both GPs and allied health professionals over the life of the projects. The total number of patients receiving care through the projects is 26 444. The total number of sessions provided to these patients is 102 120. Both the number of patients and the number of sessions have increased substantially over time. In the main, the profile of these sessions has not changed over time, with the majority being individually based, an hour in length, and consisting of CBT-based cognitive and behavioural therapies. The only notable fluctuation over time relates to the charging of a co-payment. Early sessions rarely incurred a co-payment, and where they did it was usually $10 or less; subsequent sessions more commonly involved a co-payment, sometimes of as much as $20 or more; and more recent sessions have been less commonly associated with a co-payment although the situation has not returned to the original low. Some experiences for stakeholders have remained constant over time, while others have changed. In 88% of cases, patients who have contact with allied health professionals through the ATAPS projects get better.
Seventh Interim Evaluation Report (Morley et al. 2006a)	Round 1 pilot and supplementary projects, Round 2 projects, Round 3 projects—Australia	Minimum dataset Survey of models of service delivery Project case studies	What models of service delivery are being used by the rural and urban projects? What is the level of uptake of the rural and urban projects? Who is accessing services through the rural and urban projects? What services are patients receiving through the rural and urban projects? What are the outcomes for patients through the rural and urban projects? What are the issues associated with the rural and urban projects?	Both rural and urban projects are using a mix of models. There are some notable differences in each of the domains on which models of service delivery differ, however. For example, rural projects are more likely than urban projects to directly employ allied health professionals, with 37% of the former doing so compared with only 21% of the latter. Rural projects are also less likely to have allied health professionals providing services from their own rooms (53% versus 72%). In addition, rural projects are more likely to implement direct referral systems (64% versus 38%), and less likely to use register systems (17% versus 32%). As at 31 December 2005, 1587 GPs had referred 14 137 patients to 359 allied health professionals via the rural projects. The equivalent figures for the urban projects are 1639, 16 649 and 770, respectively. The socio-demographic profiles of rural and urban patients display some important differences, as well as some similarities—e.g., although the majority of patients in both rural and urban locations are female, there are proportionally more male patients in rural settings (28% versus 26%). Similarly, the clinical profiles of rural and urban patients show some differences, but also certain commonalities—e.g., although the majority of each have depression and/or anxiety disorders, a lower proportion of rural patients have the latter (55% versus 60%). The services patients are receiving through rural and urban projects are similar in many respects, but also show some differences—e.g., the majority of sessions in both settings are 46–60 minutes in length, although a smaller proportion are of this duration in rural settings (75%

Report	Projects included	Data sources	Evaluation questions	Evaluation findings
				versus 80%) and no co-payment is charged in 82% of rural sessions, compared with only 68% of urban sessions. Both rural and urban projects are achieving positive patient outcomes. Rural projects have struck problems to do with: distance; attracting qualified staff; lack of training and support for GPs; limited services; large Indigenous populations; high levels of unemployment; and stigma. By contrast, the issues for urban projects have related more to: uptake and demand; workforce shortages; and availability of and coordination with other services. Both rural and urban projects have addressed these problems in novel and innovative ways, seeking solutions that are responsive to the local context.
Eighth Interim Evaluation Report (Morley et al. 2006b)	Round 1 pilot and supplementary projects, Round 2 projects, Round 3 projects—Australia	Minimum dataset Survey of models of service delivery	What is the level of patient outcomes within and across projects? Does the level of patient outcomes vary depending on the model of service delivery?	The projects are achieving positive effects, mostly of large or medium magnitude. This suggests that the projects are effective in improving the mental health of patients who are receiving psychological services. Projects do not differ markedly in terms of the patient outcomes they are achieving, despite their differences in models of service delivery. Only one variable emerged as significant: projects implementing direct referral systems are tending to achieve greater levels of patient outcomes. In addition, there were non-significant trends toward employment of allied health professionals being predictive of greater patient outcomes and delivery of services from allied health professionals' own rooms being predictive of lesser patient outcomes.
Ninth Interim Evaluation Report (Naccarella et al. 2006)	Round 1 pilot and supplementary projects, Round 2 projects, Round 3 and Round 4 projects—Australia	Survey of demand management strategies	How many projects are using demand management strategies? What demand management strategies are being used within projects? Which demand management strategies have been found to be most useful? What features of any demand management strategy have worked well and not worked well?	85% of projects are using at least one demand management strategy. There is considerable activity across projects with respect to demand management. The most commonly used demand management strategies are: informing/training GPs (used in 82% of projects); putting in place systems and/or administrative procedures (used in 76%); and monitoring and limiting referrals (used in 61%). The majority of projects are using a combination of broad demand management strategies (5.6 per project, on average). They are also employing a range of approaches within each demand management strategy. So, for example, within the general strategy of monitoring and limiting referrals, a given project might adopt prenumbered vouchers, track referral numbers, recall and re-allocate unused or partially used vouchers, and cap the number of referrals available to each GP. Monitoring and limiting referrals and putting in place systems and/or administrative procedures are ranked as the most useful demand management strategies, with 29% of project officers endorsing the former and 24% the latter. Different features of these demand strategies appear to work well for different projects, but a common theme is that they need to be underpinned by strong partnerships and solid infrastructure. There is concern that the need for demand management reflects the fact that projects are insufficiently resourced, and that as a consequence demand management strategies such as limiting referrals can have a negative effect on stakeholder perceptions.

TABLE 2: EXAMPLE OF ONE OF THE EVALUATION REPORTS

<table>
<tr><th colspan="2">Fifth Interim Evaluation Report: Models of Service Delivery—Profile and Association with Access (Pirkis et al. 2005)</th></tr>
<tr><td>Background</td><td>The Better Outcomes in Mental Health Care program seeks to improve the mental health care available to Australians. A key component of the program is the Access to Allied Psychological Services (ATAPS) component, which permits eligible GPs to refer patients to allied health professionals who deliver focused psychological strategies (namely psycho-education, cognitive behavioural therapy and interpersonal therapy) in six sessions with a following six sessions available upon GP review. Since the initiative began, 102 ATAPS projects have been funded in three major funding rounds. These projects are conducted by Divisions of General Practice.

National evaluation work in relation to the ATAPS projects has shown that they are operating under a range of different service delivery models. These models differ in terms of: (1) the means of retaining allied health professionals (i.e. contractual arrangements, direct employment, other); (2) the location of allied health professionals (i.e. GPs' rooms, own rooms, other); and (3) the referral mechanisms used (i.e. voucher systems, brokerage systems, register systems, direct referral, other).

Although it has highlighted the range of models and their advantages and disadvantages, to date the evaluation has not been able to quantify the employment of different models across projects. Nor has it been able to determine whether particular dimensions of the models are associated with differential levels of access for patients. The current report explores these issues.</td></tr>
<tr><td>Method</td><td>A survey was sent to Divisional representatives responsible for each of the projects, and survey data were combined with routinely collected data on the numbers of patients accessing the projects. Together, this data was used to answer the following research questions:

■ What is the profile of models of service delivery across the ATAPS projects?

■ Are particular models associated with differential levels of patient access to services?</td></tr>
<tr><td>Key findings</td><td>The survey showed that there is considerable variability across the ATAPS projects with regard to the models of service delivery being implemented:

■ In 76% of the ATAPS projects, 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).

■ 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 patients to receive free (or low-cost), evidence-based mental health care.</td></tr>
<tr><td>Conclusions</td><td>To conclude, the ATAPS projects are operating under a range of service delivery models that 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 patients. Further work is needed to determine whether different models are associated with better or worse patient outcomes, but in the meantime there is no evidence to suggest that Divisions should be modifying their locally tailored models to adopt a more uniform approach.</td></tr>
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