

Article

Managing depression in a changing primary mental healthcare system: comparison of two snapshots of Australian GPs' treatment and referral patterns

Heather McGarry MMed MBBS Grad Cert Health Prof Ed FRACGP
Lecturer, Department of General Practice

Kelsey Hegarty PhD MBBS DRANZCOG FRACGP
Associate Professor, Department of General Practice

Caroline Johnson MBBS FRACGP
PhD Student, Department of General Practice

Jane Gunn PhD MBBS DRANZCOG FRACGP
Professor, Department of General Practice

Grant Blashki MD MBBS FRACGP
Senior Research Fellow, Nossal Institute for Global Health, Faculty of Medicine, Dentistry and Health Sciences
University of Melbourne, Australia

ABSTRACT

Background Significant government spending has resulted in substantial changes to the Australian primary mental healthcare system. Initially producing the Better Outcomes in Mental Health Care (BOiMHC) initiative, this has been replaced by the Better Access to Mental Health Care programme, which allows all general practitioners (GPs) to refer patients for allied psychological health care under Medicare.

Aim To examine changes in patient management and referral for care following the BOiMHC initiative.

Method Comparison of results of a 2006 postal survey of Australian GPs examining self-reported management of patients with depression with a similar survey conducted in 2001–2002, prior to the BOiMHC initiative.

Results One hundred and thirty-three (33%) GPs responded. The main self-reported strategies for managing patients with depression were similar to the previous study: supportive counselling and medication. No significant difference was found

in rates of self-reported formal training in psychological treatments. Significantly higher rates of referral for psychological treatments were reported in 2006 than in 2002. Small trends towards higher reported referral for and reported use of psychological treatments by GPs registered for the BOiMHC initiative were noted when compared with those who were not registered.

Conclusion While GPs' main reported strategies for managing patients with depression were unchanged, reported referral for psychological therapies was significantly higher in 2006, possibly reflecting the impact of changes to the primary mental healthcare system. Ongoing rigorous evaluation of further changes to the primary mental healthcare system are needed to determine whether they deliver effective, evidence-based care, and thus to inform future programmes.

Keywords: depression, psychological treatments, referral

Introduction

Since Australia's first National Mental Health Policy in 1992, recognition of the role of general practice in providing mental health care has grown. In 2001, the Australian Federal Government moved from a spoken commitment to primary mental health care to a major funding commitment of \$120.4 million over four years to introduce change through the Better Outcomes in Mental Health Care (BOiMHC) initiative.¹ The key components of the BOiMHC initiative revolved around increasing the training, financial incentives and referral pathways for general practice to deliver care for people with mental health conditions as classified by the International Classification of Diseases (ICD-10) (see Box 1).^{2,3} The focus was on high-prevalence disorders, such as depression, and based on available evidence that specific counselling strategies such as cognitive behavioural therapy (CBT) and interpersonal therapy (IPT) may benefit people with these conditions. New Medicare item numbers were created for general practitioners (GPs) who undertook additional training in these specific psychological treatments.

By 2006, just over 20% of GPs had completed the training to gain access to this initiative.⁴ Publications relating to the impact of the BOiMHC initiative have focused on behaviours of registered GPs, such as uptake of training and Medicare claims made,⁴ and access to the allied psychological services (ATAPS) component.^{6,7} Such evaluations suggest that the ATAPS component has been the most successful

part of the initiative.⁶ Of referrals made under ATAPS, it is estimated that 90% involve psychologists.⁸ The success of this component can be seen as a key driver for introducing the Better Access to Mental Health Care programme in 2006,⁹ which subsequently replaced some components of the BOiMHC initiative, such as the way GPs are funded for providing mental health care. This programme provides Medicare rebates for allied mental health providers who treat patients for common psychological conditions following referral from a GP.⁵ Although evaluations have been published, little is known of how management compares between registered and 'unregistered' GPs, or how GPs' management changed following the introduction of this initiative. With such substantial investment and changes to the Australian primary mental healthcare system, identifying the impact of these programmes on management is vital.

In 2001–2002, prior to the introduction of these initiatives, we conducted a survey of GPs in Victoria, a state of Australia, to determine GPs' self-reported usual management of patients with depression.¹⁰ That study found 82% of GPs reported prescribing medication and 87% reported using non-specific supportive counselling with the majority of patients with mild to moderate depression. However, reported use of psychological treatments, such as CBT and problem-solving therapy (PST), was much less, with at least three-quarters reporting their use with few or none of such patients.¹⁰ Participants reporting formal training in psychiatry or CBT were more likely to report using CBT than those without formal

Box 1 Comparison of the BOiMHC initiative and Better Access programme

Better Outcomes in Mental Health Care^{2,4}

- Incentives commenced August 2002.
- GPs working in accredited practices who had completed accredited mental health training were able to receive service incentive payments (SIP) for providing care to patients with ICD-10 diagnosed mental illness. (These payments concluded April 2007.)
- Trained GPs able to refer patients for psychological therapies to the **Access to Allied Psychological Service** (ATAPS) via divisions of general practice. (Mandatory training requirement was removed November 2006.)
- **GP Psych Support** provides GPs with access to advice from psychiatrists via phone, email or fax.

Better Access to Mental Health Care⁵

- Commenced November 2006.
- All GPs regardless of training or practice location receive higher Medicare rebates to complete GP mental health plans for patients with ICD-10 diagnosed mental illness, as well as higher rebates for mental health consultations.
- Patients with an ICD-10 diagnosis and a GP mental health plan are eligible for Medicare rebates for psychological care, for up to 12 sessions per year (individual) and 12 sessions (group therapy). Alternatively, patients may be referred to the ATAPS programme (see above).

training.¹⁰ That study provided insight into how depression was managed in general practice prior to the introduction of the BOiMHC initiative. With these data available to provide a comparison, a follow-up survey was undertaken to assess changes in GPs' self-reported management of patients with depression following the introduction of this initiative.

Methodology

In 2006 a random national sample of 410 Australian GPs was obtained from Medicare Australia. Due to privacy legislation, Medicare Australia conducted all mailings on our behalf and did not release contact details of the GPs. Exclusion criteria included GPs who provided notification that they were no longer working in general practice, had left the practice without leaving a known forwarding address, or were absent from practice during the study period. A modified version of the questionnaire from our original study was used to maintain items for comparison. It included items about frequency of seeing patients with different forms of mild to moderate depression, frequency of using various management strategies, barriers to using psychological treatments, GPs' level of training, use of government initiatives and GP demographics. After pilot testing, a primer letter was sent to the study group, followed by the questionnaire with a cover letter and reply paid envelope one week later. A reminder letter and second copy of the questionnaire were sent to non-responders.

Sample size calculations were based on the proportion of GPs with training in CBT who are likely to use CBT frequently compared with GPs without training. This ensured adequate power to achieve all study objectives. The sample of 410 allowed for a 50% response rate and provided 90% power at a significance level of 5%. As our previous study found a 9% error rate in the data supplied by the Department of Health and Ageing,¹⁰ it also allowed for similar inaccuracies within the Medicare Australia dataset.

Data analysis was conducted using the STATA 9 statistical package.¹¹ Basic frequencies were calculated, and cross-tabulation between reported management strategies and selected GP demographics was conducted. Comparison was made between the original management of depression study data and the current study, using the χ^2 statistic.

Results

A 33% (133/405) response rate was achieved. Five GPs were excluded based on the listed exclusion criteria. Based on this response, the study had 83% power to detect any difference at a significance level of 5%. The responders had a similar age distribution to the original study but lower representation of GPs aged over 55 years compared with national figures (see Table 1). There was higher representation of female GPs than the national GP population and original study. Minor differences in representation of some states compared with the national GP population were noted, and GP registrars and GPs from large group practices were under-represented. Higher rates of registration for the BOiMHC initiative than national figures were reported, with 43% (56/130) reporting level one registration and 18% (19/106) reporting level two registration.

Compared with the original study, significant differences between rates of formal training (short course, diploma, certificate, degree or work at the level of psychiatry registrar or above) were only found in IPT ($P=0.03$) and relaxation therapy ($P=0.03$), with fewer responders reporting formal IPT training (current: 8.6%, 11/128; original: 17.5%, 24/137) and more reporting formal training in relaxation strategies (current: 18.6%, 24/129; original 9.3%, 13/140) in the current study. Otherwise there were no significant differences in rates of formal training.

Similar to the original study, the vast majority reported prescribing medication (80.0%, 109/130) and using supportive counselling (89.2%, 116/130) to treat half or more of their patients with mild to moderate depression in the previous six months. A smaller proportion reported using psychological treatments frequently, with 21.9% (28/128) providing PST, 17.2% (22/128) providing CBT and 12.3% (15/122) providing IPT to half or more patients with mild to moderate depression in the previous six months. Responders were more likely to report using CBT frequently if they reported formal training in psychiatry ($P=0.01$), CBT ($P<0.001$) or PST ($P=0.01$). An association was also found between reported frequent use of IPT and formal training in IPT ($P=0.01$).

Significantly higher proportions of responders than in the original study reported recommending exercise, providing drug and alcohol or family or marital counselling, or teaching meditation and relaxation techniques to half or more of their patients (see Table 2). There was no significant difference in reported rates of use of medication, PST or CBT between the studies. The most frequently reported influences on not providing psychological treatments included lack of time (93.4%, 113/121), lack

Table 1 Responders' demographics compared with the original study¹⁰ and national figures^{12,13}

	Original study, <i>n</i> = 153, <i>n</i> (%)	Current study, <i>n</i> = 133, <i>n</i> (%)	National, <i>n</i> = 22 954, <i>n</i> (%)
Sex			
Male	103 (67.3)	69 (52.3)	14331 ^a (62.4)
Female	50 (32.7)	63 (47.7)	8622 (37.6)
Age (years)			
<35	16 (10.5) ^b	10 (7.5)	1995 (8.7)
36–54	102 (66.7)	84 (63.2)	13613 (59.3)
55+	35 (22.9)	39 (29.3)	7346 (32.0)
Qualifications			
Vocational registration	N/A ^c	108 (81.8)	19689 (85.8)
FRACGP	64 (43.8)	67 (50.8)	
GP trainee	8 (5.5)	1 (0.8)	1806 (7.9)
State			
Australian Capital Territory	N/A ^d	3 (2.3)	446 (1.9)
New South Wales	N/A	40 (30.8)	7689 (33.5)
Northern Territory	N/A	2 (1.5)	306 (1.3)
Queensland	N/A	26 (20.0)	3743 (16.3)
South Australia	N/A	12 (9.2)	1879 (8.2)
Tasmania	N/A	6 (4.6)	609 (2.7)
Victoria	153 (100)	29 (22.3)	5865 (25.6)
Western Australia	N/A	12 (9.2)	2418 (10.5)
Practice type			
Solo	25 (17.2)	21 (15.9)	3326 ^e (15.6)
Small group (<5)	69 (47.6)	57 (43.2)	7276 (34.1)
Large group (5+)	51 (35.2)	54 (40.9)	10764 (50.4)
Registered for BOiMHC?			
Level one	N/A ^f	56 (43.0)	(22.0) ¹⁴
Level two	N/A	19 (17.9)	(4.5)
Not registered	N/A	74 (56.9)	(78.0)

^a As published¹³; ^b Percentages may not equal 100 due to rounding; ^c Not included in original survey; ^d Victorian sample group; ^e Denominator = 21366 due to missing data¹³; ^f Conducted prior to BOiMHC initiative

of training in these techniques (81.0%, 98/121) and lack of confidence in skills (83.3%, 100/120).

Significantly higher proportions of responders in the current study reported referring half or more of their patients with mild to moderate depression for PST ($P < 0.001$) or CBT ($P < 0.001$). In fact, significantly more responders reported higher rates of referral for most modalities compared with our original study (see Table 3).

When comparison was made between responders who were and were not registered for the BOiMHC initiative, a trend emerged towards those who were registered being more likely to report provision of the listed strategies to greater proportions of patients than those who were not registered (see Table 4). A

similar small trend was noted with regard to reported referral for specific psychological treatments (see Table 5). Numbers were too small for reliable analysis of these figures.

Discussion

This project has provided information about GPs' self-reported management of depression, including both GPs who registered for the BOiMHC initiative and those who did not.

Table 2 Comparison of reported frequency of use of different treatment strategies between original¹⁰ and current study

Method	Original		Current		<i>P</i> value
	<i>n</i>	(%)	<i>n</i>	(%)	
Prescribed medication					
Less than half	27	(17.9)	26	(20.0)	0.65
Half or more	124	(82.1)	104	(80.0)	
Provided supportive counselling					
Less than half	19	(12.7)	14	(10.8)	0.62
Half or more	131	(87.3)	116	(89.2)	
Encouraged exercise					
Less than half	40	(27.4)	18	(13.7)	0.01
Half or more	106	(72.6)	113	(86.3)	
Provided drug and alcohol counselling					
Less than half	132	(88.0)	79	(61.2)	<0.001
Half or more	18	(12.0)	50	(38.8)	
Provided family or marital counselling					
Less than half	125	(84.5)	93	(72.7)	0.02
Half or more	23	(15.5)	35	(27.3)	
Taught meditation/relaxation techniques					
Less than half	135	(91.2)	102	(79.7)	0.01
Half or more	13	(8.8)	26	(20.3)	
Taught problem-solving therapy					
Less than half	122	(81.9)	100	(78.1)	0.44
Half or more	27	(18.1)	28	(21.9)	
Used cognitive-behavioural therapy					
Less than half	127	(85.2)	106	(82.8)	0.58
Half or more	22	(14.8)	22	(17.2)	

Denominators may vary due to missing data

While the main reported methods for managing patients with depression and rates of formal mental health training are essentially unchanged from the original study, significantly higher rates of referral were reported in the current study. Trends in the data suggested that GPs registered for the BOiMHC initiative were both providing psychological treatments and referring for them at higher rates than unregistered GPs; however, the numbers available for analysis were too small to reliably draw conclusions about this.

The opportunity to compare data collected prior to and subsequent to the introduction of the BOiMHC initiative is a strength of this study. However, there are a number of limitations. Although typical for primary care surveys of Australian GPs,^{10,15,16} the response rate is relatively low at 33%. Also, nothing is known of the non-responders and how they may

differ from responders. A higher proportion of female GPs responded to the current project than the original, and a greater proportion of responders reported BOiMHC initiative registration compared with the concurrent national rate of registration, which may influence reported management. Definitions were not provided for each strategy and so it is possible that not all participants interpreted them in the same way. Additionally, although a comparable questionnaire was used, differences may exist due to geographic diversity when comparing Victorian with national data.

There has been a huge investment in primary mental health care in Australia, and evaluation of the impact is vital. While the current study does not evaluate the BOiMHC initiative, the findings suggest that primary care practice has been influenced by this investment. While reported provision of supportive

Table 3 Comparison of reported frequency of referral for different treatments between original¹⁰ and current study

Method	Original		Current		P value
	n	(%)	n	(%)	
Referred for supportive counselling					
Less than half	91	(62.8)	62	(49.2)	0.03
Half or more	54	(37.2)	64	(50.8)	
Referred for drug and alcohol counselling					
Less than half	144	(96.0)	114	(90.5)	0.06
Half or more	6	(4.0)	12	(9.5)	
Referred for family or marital counselling					
Less than half	141	(95.3)	105	(83.3)	0.001
Half or more	7	(4.7)	21	(16.7)	
Referred for meditation/relaxation techniques					
Less than half	131	(89.1)	94	(75.2)	0.002
Half or more	16	(10.9)	31	(24.8)	
Referred for problem-solving therapy					
Less than half	140	(95.2)	100	(80.0)	<0.001
Half or more	7	(4.8)	25	(20.0)	
Referred for cognitive-behavioural therapy					
Less than half	132	(89.8)	91	(71.6)	<0.001
Half or more	15	(10.2)	36	(28.4)	

Denominators may vary due to missing data

counselling and prescription of medication remains essentially unchanged, drug and alcohol, family counselling and lifestyle options were reported to be provided at higher rates in the current study. Also, of particular significance in the context of ongoing changes in the Australian primary mental health-care system, is the finding of significantly increased reported rates of referral for psychological treatments. This difference does not appear to simply result from comparison being made between national and state-based figures, as comparison of Victorian GPs' reported referral patterns within the current study with the study population as a whole found reported rates of referral by Victorian GPs are the same or higher.

Ease of access provided by Medicare funding of allied psychological services through GP referral may be an important reason for this change in reported referral rates, which suggests that a previously unmet need for such services is being addressed. However, there are other influences that may also impact referral. Community education campaigns by organisations such as *beyondblue*, which works to increase community understanding of common mental illnesses in Australia,¹⁷ have informed the community

about available services for mental health care and encouraged people to seek help if they are affected by mental illness. Such education could result in people requesting or accepting referral more readily. Workforce issues could also influence referral rates. Mental health care is time consuming and the current environment of GP shortage and high demands may influence GPs to refer more when the option is readily available to them. This is consistent with responders' reports that lack of time was the most influential factor in their not providing psychological treatments for patients with depression.

With evidence that specific psychological treatments offer effective treatment options for depression,¹⁸ the challenge internationally is to determine how to provide adequate access to such treatments. Varied approaches are being adopted in different countries. In the UK, the government has committed substantial funding to the Improving Access to Psychological Therapies programme (IAPT), which commenced with two demonstration sites in 2006 and continues to expand.^{19,20} It aims to support provision of regional community-based treatment for patients with depression or anxiety disorders in line with the National Institute for Health and Clinical

Table 4 BOiMHC initiative registration versus reported frequency of strategy use

Strategy/level of registration	Less than half, <i>n</i> (%)	Half or more, <i>n</i> (%)
Provide supportive counselling		
Not registered	8 (12.5)	56 (87.5)
Registered	5 (7.9)	58 (92.1)
Prescribe medication		
Not registered	16 (24.6)	49 (75.4)
Registered	9 (14.5)	53 (85.5)
Taught problem-solving therapy		
Not registered	53 (84.1)	10 (15.9)
Registered	44 (71.0)	18 (29.0)
Provide cognitive-behavioural therapy		
Not registered	59 (93.7)	4 (6.4)
Registered	45 (72.6)	17 (27.4)
Provide interpersonal therapy		
Not registered	55 (93.2)	4 (6.8)
Registered	49 (81.7)	11 (18.3)
Provide drug and alcohol counselling		
Not registered	41 (65.1)	22 (34.9)
Registered	37 (58.7)	26 (41.3)
Provide family/marital counselling		
Not registered	49 (76.6)	15 (23.4)
Registered	41 (67.2)	20 (32.8)
Teach meditation/relaxation techniques		
Not registered	56 (88.9)	7 (11.1)
Registered	44 (71.0)	18 (29.0)

Denominators may vary due to missing data

Excellence (NICE) guidelines and includes funding for training therapists to provide recommended psychological therapies. In New Zealand, rather than utilising a standard national model as in the UK and Australia, the Ministry of Health has funded primary mental health initiatives (PMHIs) to improve community treatment of common mental health disorders.²¹ These provide improved access to services such as longer GP consultations, psychological therapies and social support networks through a variety of regional service models designed to meet local needs.

In Australia, the BOiMHC initiative appears to address a need for easier access to psychological treatments through GP referral to allied psychological services, which is being carried over in ongoing changes to the primary mental healthcare system. However, the broader impact of the BOiMHC initiative on mental health care is not clear, with many other factors potentially impacting behaviours. For

countries seeking to identify efficient and effective primary mental healthcare strategies, robust evidence is required from interventions to ensure programme development is likely to result in desired community outcomes. To this end, high-quality evaluation must be embedded in programme planning and design,²² to identify the extent to which changes in practice are attributable to the intervention. Without such evaluation, it remains difficult to be certain of the true effects and whether money spent is improving provision of evidence-based mental health care.

Conclusions

While the main reported strategies for managing patients with depression did not significantly change, reported rates of referral for psychological therapies

Table 5 Level of BOiMHC initiative registration versus frequency of referral

Strategy/level of registration	Less than half, <i>n</i> (%)	Half or more, <i>n</i> (%)
Refer for supportive counselling		
Not registered	26 (40.6)	38 (59.4)
Registered	33 (55.9)	26 (44.1)
Refer for problem-solving therapy		
Not registered	52 (83.9)	10 (16.1)
Registered	45 (75.0)	15 (25.0)
Refer for cognitive-behavioural therapy		
Not registered	46 (73.0)	17 (27.0)
Registered	42 (68.9)	19 (31.2)
Refer for interpersonal therapy		
Not registered	56 (96.6)	2 (3.5)
Registered	55 (90.2)	6 (9.8)
Refer for drug and alcohol counselling		
Not registered	55 (88.7)	7 (11.3)
Registered	56 (91.8)	5 (8.2)
Refer for family/marital counselling		
Not registered	54 (87.1)	8 (12.9)
Registered	48 (78.7)	13 (21.3)
Refer for meditation/relaxation techniques		
Not registered	49 (79.0)	13 (21.0)
Registered	42 (70.0)	18 (30.0)

Denominators may vary due to missing data

were significantly higher in 2006. This difference may reflect changes to the primary mental health-care system, but may also be influenced by other societal and workforce issues. Continuing evaluation is necessary to determine whether system changes improve delivery of evidence-based care and to inform future developments in primary mental health care, both in Australia and internationally.

ACKNOWLEDGEMENTS

We would like to acknowledge the contributions of Drs Marie Pirotta and David Pierce to the design and conduct of this research. Additionally, we thank the GPs who completed the surveys, without whom this work could not have been completed.

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- #### FUNDING
- Funding for this research was received from the diamond Consortium which is funded by the *beyondblue* Victorian Centre of Excellence in Depression and Related Disorders.
- #### ETHICAL APPROVAL
- The Human Research Ethics Committee of the University of Melbourne provided ethics approval for this project.
- #### CONFLICTS OF INTEREST
- None.
- #### ADDRESS FOR CORRESPONDENCE
- Dr H McGarry, Department of General Practice, University of Melbourne, 200 Berkeley Street, Carlton, Victoria, Australia, 3053. Tel: +61 3 8344 6186; fax: +61 3 9347 6136; email: h.mcgarry@unimelb.edu.au
- Accepted 17 August 2009*

