Title: Why have Divisions of General Practice implemented some ATAPS mental health initiatives and not others?

Abridged title: Implementation of ATAPS Tier 2 initiatives by Divisions

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1. What is known about the topic?

Previous evaluations of ATAPS have shed light on some of the factors that act as barriers to the implementation of new mental health initiatives by Divisions operating in primary care, but there is nothing known about why Divisions choose to implement some programs over others. Previous research suggests that 'barriers' to change as reported by organisations may be constructions that are used to make sense of a situation, and that the real impediment to change is the self-identity of organisations.

2. What does this paper add?

This paper reports on a survey that was undertaken with Divisions regarding the reasons they chose to implement particular mental health initiatives. The paper provides insight into the barriers that Divisions perceived when implementing new mental health programs, primarily citing funding and resource barriers. The findings also provide further indirect evidence of the role of the self-identity of organisations in change.

3. What are the implications for practitioners?

The study has some implications for government policy development both locally and internationally. For instance, it is likely that primary care organisations such as Divisions, especially smaller ones, require support in terms of increased funding and resources if new mental health initiatives are to be successful. Mandating the delivering of initiatives also contributes to their successful uptake. It is likely that as primary care organisations become more experienced with implementing new mental health programs that the perceived barriers will reduce and implementation will occur with more ease.
Introduction

In July 2001, the Better Outcomes in Mental Health Care program was introduced by the Australian government. The Access to Allied Psychological Services (ATAPS) program component of this program enables patients with common mental health disorders to receive free or low-cost evidence-based treatment from mental health professionals over 12 sessions (or 18 in exceptional circumstances). At the time of this study, ATAPS was managed by Divisions of General Practice (Divisions). In 2011-12, Divisions were replaced by Medicare Locals and, following changes recommended by the Australian Government in 2014, will once again change to larger primary health care organisations. The term ‘Divisions’ will be used throughout this article to describe these organisations consistent with the terminology used at the time of the survey, except where the findings are particularly relevant to Medicare Locals.

Since 2008, various government policy changes have seen the introduction of funding for several new ATAPS initiatives (now known as Tier 2, whilst the original ATAPS is known as Tier 1) in order to enhance the capacity of Divisions to address the needs of specific groups: people at risk of suicide; children; women with perinatal depression; people who are experiencing, or are at high risk of, homelessness; Aboriginal and Torres Strait Islander people; and those in rural and remote areas.\(^1\) Funding has also been provided at different times to those Divisions impacted by extreme climatic events including bushfires, floods and cyclones. ATAPS Tier 1 funding is somewhat adaptable, with Divisions able to tailor programs to suit their local needs and context. Tier 2 initiatives offer even greater flexibility in the way they are delivered; for example, by allowing a greater number of sessions, service delivery in alternative locations or referrals from different health professionals.

At the time of this study in 2012, services for those at risk of suicide, and women with perinatal depression were mandatory for Divisions unless they demonstrated that the initiative duplicated existing services. Divisions could choose to adopt the other initiatives depending on the perceived needs of their community.

We have been undertaking an evaluation of ATAPS since 2003. This evaluation primarily involves the use of a web-based minimum dataset that collects referral, session, and consumer data for all consumers of the ATAPS program. To date, this dataset contains data related to over 1,000,000 ATAPS sessions. In addition, throughout the evaluation, qualitative data has been collected via surveys to address particular evaluation questions. Through our ongoing evaluation of ATAPS we noted that despite the provision of extra funding for Tier 2 services, many Divisions were either not yet delivering the services, or had delivered a relatively low number of sessions via the services. We wanted to understand why services had not yet been implemented for people that were likely to be at increased need of psychological services.
Greenhalgh et al’s (2004)\(^{(2)}\) systematic review relating to spreading and sustaining innovations in health service delivery highlights an extensive number of factors both internal and external to an organisation that can affect the implementation of innovations. In sum, they show that innovations that have a clear, unambiguous advantage over existing services or products; are compatible with the intended adopters' values, norms and perceived needs; are perceived as simple to use; can be experimented with; have visible benefits; have required knowledge that can be transferred from one context to another; and that can be adapted and refined to suit their own needs are likely to be adopted more easily. With these factors in mind, Divisions seem ideally situated to implement new mental health programs in the primary care context, as they possess both an existing framework within which to do so and compatible goals for the health of their local communities.

A similar study to the one undertaken here explored the adoption of imposed bureaucratic policy initiatives in English general medical practice.\(^{(3)}\) The authors drew on sociological theory and proposed that while many studies look at 'barriers to change' as reasons for why changes are not integrated into primary care organisations, it may be that the principal activity taking place is actually 'sensemaking'.\(^{(4)}\) That is, organisations seek to construct an organisation that conforms to their beliefs and assumptions, and it is this self-identity that actually impedes change. They further proposed that reported 'barriers to change' are constructions used by participants to make sense of the situation. Thus, research that identifies barriers and facilitators to change, as well as the organisational and social context of the organisation can promote more effective implementation of new innovations.

This study aimed to determine the factors that have affected the uptake of ATAPS Tier 2 initiatives by Divisions. The study considered barriers to implementation as described by Divisions. The findings could inform government mental health policy and processes, provide an opportunity for Divisions' to learn from each other, and are also potentially relevant to policy makers implementing other primary health care programs.

**Method**

**Data sources**

*Online survey of Divisions*

The evaluators designed a 14-question survey to investigate Divisions’ decision making regarding the initiatives they would implement. Topics addressed by the survey included:

- Divisions’ delivery of initiatives in the past, present and future
- factors influencing the Divisions’ decision to implement the chosen initiatives
- factors influencing the decision not to implement certain initiatives
The perceived impact of ATAPS Tier 2 initiatives on consumers and the Division.

The survey response options were informed by findings of our previous evaluations of the pilot Suicide prevention and Telephone-CBT initiatives, which had included a survey component.\(^5\) These evaluations explored, among other things, the benefits and challenges experienced by Divisions in implementing these new Tier 2 initiatives. The common themes that emerged from these evaluations were used to provide some of the multiple choice response options for the current study's survey. In the current survey, participants could endorse as many factors as were relevant, which included options such as ‘directive from the Department of Health’, ‘awareness of local need’, and ‘clinician interest and skills’.

Once a survey was drafted, four Divisions were contacted for their opinions on the suitability of the survey content. The final survey contained mostly multiple-, forced-choice answers. An email was sent by the evaluation team to all ATAPS Divisions inviting them to complete the online survey via a unique link provided in the email. The survey data was obtained between May and June 2012.

**The Divisions of General Practice Atlas, 2012**

In order to determine the potential need for initiatives within Division areas, *The Divisions of General Practice Atlas, 2012* online data\(^8\) was used to obtain statistics on social indicators. The percentage of the population made up of Aboriginal and Torres Strait Islander people and children were identified for each Division area, as were the fertility rates and avoidable mortality rates by suicide and self-harm (only combined data regarding mortality rates by suicide and self-harm were available). These data were used as a preliminary indicator of a Division’s level of need for the Tier 2 services for Aboriginal and Torres Strait Islander people, children, women with perinatal depression, and those at risk of suicide. Rates for homelessness were not available, and the need for the other initiatives was deemed to be based on specific geographic or situational needs, such as mental health needs related to bushfires, floods and cyclones, and rural or remote locale.

**Data analysis**

Frequencies for the chosen response options for each question were determined using SPSS version 19. Division-level data related to the social indicators were identified for each Division that participated in the survey. The presence or absence of the relevant initiatives was then compared with these data.

**Participants**
All 105 Divisions implementing ATAPS at the time of the study were invited to participate. Eighty-three participants took part. As some participants represented more than one Division the total number of Divisions represented was 92. The response rate was therefore 88% from the 105 Divisions contacted.

Results

Survey Results

Implementation of Tier 2 initiatives

The majority of participants (72%) reported that their Divisions were currently delivering between two and four Tier 2 initiatives. Figure 1 shows the delivery status of each initiative as reported by participants. Note that the responses are shown per respondent (N=83).

[FIGURE 1 ABOUT HERE]

The Suicide Prevention initiative, available since July 2010 (and as a demonstration pilot in 19 Divisions between 2008 and 2010) and the Perinatal initiative, implemented in April 2008, had been available for the longest time and also had the highest rates of implementation. As expected, the Bushfire, and Floods and Cyclone Yasi initiatives have the lowest rate of delivery due to their exclusive availability to Divisions affected by these disasters.

Factors influencing choice of initiatives

The three factors most frequently endorsed (or more if factors were equally endorsed) as 'strongly influencing' a Division's decision to implement an initiative and not implement an initiative are shown for each initiative in Table 1.

[TABLE 1 ABOUT HERE]

Effect of initiatives on consumers and Divisions

Participants almost unanimously rated as positive or very positive the impact of the initiatives on consumers. However, while the majority of Divisions reported that the impact on Divisions was positive or very positive, some reported that the impact had been negative. This was most noticeable for the Suicide Prevention initiative with 22% of Divisions rating the impact as negative or very negative.

Comparisons were made between the 22 Divisions who had more experience implementing Tier 2 programs (those who had been involved in piloting the Suicide Prevention of T-CBT initiatives) and other
Divisions. These 22 Divisions saw the impact of initiatives on Divisions as generally more positive than other Divisions.

**Qualitative data**

Participants had an opportunity to provide any further general comments about the implementation of their Tier 2 initiatives. Nineteen participants provided such comments. These comments were quite diverse and many related to logistical and procedural factors. For instance, issues around insufficient funding were raised by seven participants. Five participants reported difficulties implementing services in relation to specific groups that were either difficult to engage or required suitably qualified providers that were difficult to find. Five participants mentioned issues regarding mental health professional and GP workforce shortages, which made it difficult to either up-skill or employ new professionals.

**The Divisions of General Practice Atlas, 2012**

Table 2 shows both the social indicator statistics for Divisions and whether the Division is delivering those initiatives the social indicators suggest would be in demand. Only the 20 Divisions with the highest prevalence or rate for each indicator are shown; this figure was chosen arbitrarily to indicate the areas of highest needs. Division names are omitted.

For the 20 Divisions shown in Table 2, the rate of each social indicator is higher than the national rate. It can be seen that initiatives were not all being delivered in these areas of potential need. Many of the areas where the Aboriginal and Torres Strait Islander and Child initiatives were not being delivered were those with smaller populations.

Discussion

The findings are affected by some limitations. Firstly, the survey was undertaken during a time of transition for Divisions, as they moved to operate as Medicare Locals. However, the transition was only cited as influencing Divisions’ decisions not to adopt certain programs in a small number of cases. Secondly, population statistics of social indicators provide only a crude indicator of population need and do not take into account other aspects of the local context. Furthermore, not all the data available in the Divisions of General Practice Atlas, 2012 is recent, with some indicators having not been updated since 2006. Also, the findings of the study were limited by the survey response options provided to participants, which were based on our previous evaluation work. These options were very much related to situation and context and did not explore the more subtle factors internal to organisations that can impact implementation, such as
Greenhalgh et al's (2004) proposed system antecedents for innovation, namely the organisation's structure, absorptive capacity for new knowledge and the receptive context for change.

The variable uptake of the Tier 2 ATAPS initiatives suggests that further work and support is needed to assist Divisions to achieve optimal implementation of the initiatives. Decisions not to implement initiatives were influenced primarily by practical considerations related to funding and resources rather than to a perceived lack of need or a duplication of existing services. Therefore, while a Division might identify the need for a particular initiative within its community, a perceived lack of adequate resourcing for its implementation could override the decision to implement it. The findings also suggest that programs have the most success, as measured by the numbers of referrals received and sessions delivered, when their implementation is made mandatory by the funding body. This positive impact of a ‘policy push’ was also found by Greenhalgh et al (2004); however, they caution that external mandates may divert activities away from the program as organisations spend time second guessing what they are required to do, especially if the organisation is not ready for change.

Divisions with smaller populations were shown to be particularly likely to have a high need for some initiatives, but not to be implementing them. Perhaps with fewer resources, these smaller Divisions are finding implementation particularly challenging. This might be overcome by the recent move for Divisions to operate as much larger Medicare Locals, and will be further impacted by a recent Government decision to move to even fewer primary health care organisations of larger size and scope. It could be that larger organisations enable efficiencies in service implementation, however, there is also a risk that large organisations that service a large population are less in touch with local community service needs, thus resulting in less effective services.

It is also important to consider the proposal that reported issues with implementing the new initiatives may be constructions generated to explain a lack of change and that the self-identity of the organisation may be more crucial to change, as suggested by the aforementioned work on ‘sensemaking’ by Weick (2001). Weick’s work proposes that organisations hold an image of themselves that is constantly updated through interactions with others, and that they work to retrospectively make situations rationally accountable and consistent with this image. Thus, initially a Division may resist implementing an initiative if it is not compatible with their image, then retrospectively develop constructions to explain this lack of implementation, but over time the image they hold of themselves changes to accommodate the implementation of the initiative.
This proposal is supported by the finding here that Divisions with more experience of implementing new initiatives, perceived more positive impacts of the initiatives. Similarly, our previous evaluations have also found a reduction in reported negative impacts and barriers to implementation as experience with implementation increased. This increase in perceived positive impacts and reduction in perceived barriers may be due simply to Divisions finding solutions to problems over time, or could be due to a change in the self-identity of the organisation that integrates the new program. Either way, it seems likely that as Divisions become more experienced with implementing new programs, their capacity to introduce other new programs increases. This increased capacity to implement new programs might occur through a change in their self-identity, as suggested by Weick (2001), a change in the organisation’s capacity to absorb new knowledge, and a greater receptiveness to change, as suggested by Greenhalgh et al (2004).

Further research should aim to better understand what factors contribute to the uptake and sustainability of new initiatives in primary health care organisations. For example, further research could explore in more detail what features account for the success of an initiative in one Division but not another. A repeat of this study once the proposed larger primary health care organisations are fully established could further elucidate the processes that are impacting on the implementation of new mental health initiatives. Further research could examine intra-organisational factors as suggested by Greenhalgh et al (2004), such as the receptiveness to change and capacity to absorb new knowledge, as well as contextual factors such as the ones highlighted in this research. Assessing intra-organisational factors could be quite challenging, for instance, the participants in the current study were provided with opportunity to provide open-ended feedback to questions, but did not volunteer any information related to intra-organisational factors.

The Australian Department of Health already has a number of policy initiatives in place to assist Divisions with the implementation of new mental health programs. These include the provision of ‘start up’ funding that allows Divisions to undertake service planning and development prior to direct service delivery; funding for dedicated staff who undertake service co-ordination and liaison; and DVD training to provide clinical staff with the specialised skills required for the new programs. Other policy initiatives could include a funding model that provides for the indirect costs associated with servicing hard-to-reach target groups. For example, specific funding could be provided for transport and accommodation to provide outreach services. Opportunities could also be provided for Divisions to share knowledge and resources with each other and problem solve any challenges experienced. This knowledge sharing could be facilitated through forming inter-Division working groups or online forums. Greenhalgh et al (2004) caution that such networks can be effective but should be carefully managed to prevent them serving to dissuade adoption of innovations. A way to overcome this may be for more experienced organisations in this instance,
Divisions who have implemented pilot initiatives and who feel more positively about them) to act as mentors to less experienced or smaller organisations.

**Conclusion**

Tier 2 ATAPS initiatives use an innovative approach to Government-funded mental health care by providing Divisions with greater flexibility and choice in the implementation of initiatives to meet the needs of their community and through their targeting at specific hard-to-reach groups. Despite this, a number of Divisions have not yet implemented certain initiatives that would appear to be in high demand within their catchment population, primarily citing funding and resource barriers to their implementation.

While a flexible approach to primary mental health care to meet local need can be a great motivator for implementation of innovative programs, this needs to be supported by adequate funding, resources and practical support to assist organisations to create a service delivery context that can easily integrate these new programs. It is also likely that new mental health programs will be implemented with increasing ease as Divisions (now Medicare Locals, and soon to be even larger primary health care organisations) become more experienced at implementation.
Declaration of Interest:
This evaluation is funded by the Australian Commonwealth Department of Health.
References


Figure 1: Implementation of ATAPS sub-programs across Divisions as reported by participants (N=83)
Table 1: Factors that have influenced Divisions’ decisions to implement or not implement each Tier 2 initiative

<table>
<thead>
<tr>
<th>Factors related to a decision to implement</th>
<th>Aboriginal and Torres Strait Islander</th>
<th>Bushfire</th>
<th>Child</th>
<th>Floods and Cyclone Yasi</th>
<th>Homelessness</th>
<th>Perinatal depression</th>
<th>Rural and remote</th>
<th>Suicide prevention</th>
</tr>
</thead>
<tbody>
<tr>
<td>n=57</td>
<td>n=7</td>
<td>n=69</td>
<td>n=8</td>
<td>n=38</td>
<td>n=82</td>
<td>n=31</td>
<td>n=83</td>
<td></td>
</tr>
<tr>
<td>Perceived local need</td>
<td>38 (58%)</td>
<td>38 (55%)</td>
<td>5 (63%)</td>
<td>17 (45%)</td>
<td>29 (35%)</td>
<td>19 (61%)</td>
<td>40 (48%)</td>
<td></td>
</tr>
<tr>
<td>Supportive existing service structure</td>
<td>26 (40%)</td>
<td>1 (14%)</td>
<td>26 (38%)</td>
<td>4 (50%)</td>
<td>14 (37%)</td>
<td>28 (34%)</td>
<td>73 (88%)</td>
<td></td>
</tr>
<tr>
<td>Directed to deliver by the Department</td>
<td>32 (46%)</td>
<td>32 (46%)</td>
<td>4 (50%)</td>
<td>10 (26%)</td>
<td>41 (50%)</td>
<td>14 (45%)</td>
<td>25 (30%)</td>
<td></td>
</tr>
<tr>
<td>Consumer interest</td>
<td>5 (71%)</td>
<td>4 (50%)</td>
<td>5 (71%)</td>
<td>10 (26%)</td>
<td>28 (34%)</td>
<td>14 (45%)</td>
<td>14 (45%)</td>
<td></td>
</tr>
<tr>
<td>Good relationships with relevant local agencies</td>
<td>5 (71%)</td>
<td>5 (71%)</td>
<td>5 (71%)</td>
<td>10 (26%)</td>
<td>28 (34%)</td>
<td>14 (45%)</td>
<td>14 (45%)</td>
<td></td>
</tr>
<tr>
<td>Interested/skilled mental health professionals</td>
<td>27 (42%)</td>
<td>27 (42%)</td>
<td>27 (42%)</td>
<td>27 (42%)</td>
<td>27 (42%)</td>
<td>27 (42%)</td>
<td>27 (42%)</td>
<td></td>
</tr>
<tr>
<td>Already delivering these via Tier 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>14 (45%)</td>
<td>14 (45%)</td>
<td></td>
</tr>
<tr>
<td>GP interest</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>14 (45%)</td>
<td>14 (45%)</td>
<td></td>
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</table>

Factors related to a decision not to implement

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<th>n=27</th>
<th>N/A</th>
<th>n=23</th>
<th>N/A</th>
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<th>N/A</th>
<th>n=31</th>
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<tr>
<td>Insufficient funding</td>
<td>8 (30%)</td>
<td>9 (39%)</td>
<td>19 (37%)</td>
<td>19 (37%)</td>
<td>21 (36%)</td>
<td>21 (36%)</td>
<td></td>
</tr>
<tr>
<td>Division administration capacity</td>
<td>4 (15%)</td>
<td>3 (13%)</td>
<td>11 (21%)</td>
<td>10 (17%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Demand for ATAPS is not high enough</td>
<td>4 (15%)</td>
<td>3 (13%)</td>
<td>11 (21%)</td>
<td>10 (17%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No local need identified</td>
<td>4 (15%)</td>
<td>3 (13%)</td>
<td>12 (23%)</td>
<td>19 (33%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Waiting for the transition to Medicare</td>
<td>4 (15%)</td>
<td>6 (26%)</td>
<td>12 (23%)</td>
<td>19 (33%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Service duplication</td>
<td>6 (22%)</td>
<td></td>
<td></td>
<td></td>
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</table>

*a* Percentages add to more than 100% as multiple influences could be endorsed.
### Table 2: Division-level social indicator data and implementation status of the Tier 2 initiatives

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<tbody>
<tr>
<td></td>
<td>Total pop.</td>
<td>% of pop.</td>
<td>ATSI program</td>
<td>Division</td>
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<td>1</td>
<td>31,928</td>
<td>47.4</td>
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<tr>
<td>2</td>
<td>16,179</td>
<td>28.8</td>
<td>Yes</td>
<td>2</td>
</tr>
<tr>
<td>3</td>
<td>105,192</td>
<td>22.3</td>
<td>Yes</td>
<td>3</td>
</tr>
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<td>4</td>
<td>44,089</td>
<td>16.9</td>
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<tr>
<td>5</td>
<td>26,732</td>
<td>15.7</td>
<td>No</td>
<td>5</td>
</tr>
<tr>
<td>6</td>
<td>107,763</td>
<td>14.2</td>
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<td>6</td>
</tr>
<tr>
<td>7</td>
<td>51,675</td>
<td>12.5</td>
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<td>8</td>
<td>55,436</td>
<td>11.2</td>
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<td>9</td>
<td>62,628</td>
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<td>10</td>
<td>140,199</td>
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<td>11</td>
<td>62,635</td>
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<td>12</td>
<td>65,429</td>
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<td>15</td>
<td>48,702</td>
<td>5.0</td>
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<td>16</td>
<td>63,356</td>
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<td>17</td>
<td>151,212</td>
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