STRATEGIC PLANNING GROUP FOR

SPGPPS

PRIVATE PSYCHIATRIC SERVICES

REPORT OF THE
FORTIETH
(40TH)
MEETING

HELD AT
NEW FARM CLINIC
22 SARGENT STREET
NEW FARM
BRISBANE
QUEENSLAND

ON
FRIDAY, 24 JUNE 2005

REPORT OF MEETING

Glossary of Acronyms and Terms used repeatedly in this Report

ABS	Australian Bureau of Statistics	IMWG	SPGPPS Innovative Models Working Group
ACHS	Australian Council on Healthcare Standards	ISC	AHMAC NMHWG Information Strategy Committee
AHIA	Australian Health Insurance Association	ISWG	SPGPPS Information Strategy Working Group
AHMAC	Australian Health Ministers Advisory Council	MBS	Medical Benefits Schedule
AMA	Australian Medical Association	MET	Motivational Enhancement Therapy
APHA	Australian Private Hospitals Association	MTEC	Medical Training and Education Council
BOiMHC	Better Outcomes In Mental Health Care	NDARC	National Drug and Alcohol Research Centre
CBT	Cognitive Behavioural Therapy	NMHWAC	AHMAC National Mental Health Workforce Advisory Committee
CDMS	SPGPPS Centralised Data Management Service	NMHWG	AHMAC National Mental Health Working Group
CNS	Central Nervous System	PHIAC	Private Health Insurance Administrative Council
CPoC	Consumer Perceptions of Care measure	PPHG	Promoting Private Health Group
DoHA	Australian Government Department of Health and Ageing	RACGP	The Royal Australian College of General Practitioners
GPMHSC	General Practice mental Health Standards Collaboration	RANZCP	The Royal Australian and New Zealand College of Psychiatrists
GP(s)	General Practitioner(s)	SDWG	SPGPPS Substance Abuse and Dependency Working Group
HCP	Hospital Casemix Protocol	TCA	Tricyclic Antidepressants
Health Fund(s)	Private Health Insurance Fund(s) that pay benefits for psychiatric care	SPGPPS	Strategic Planning Group for Private Psychiatric Services
Hospital(s)	Private Hospital(s) with psychiatric beds	SSRI	Selective Serotonin Re–uptake Inhibitor
ICD	International Classification of Diseases		

The Fortieth (40th) SPGPPS Meeting (or the Meeting) was held on Friday, 24 June 2005 at the New Farm Clinic, Brisbane.

1. PROCEDURAL MATTERS

1.1 OPENING AND WELCOME

Dr Yvonne White opened the meeting at 9:30 AM and welcomed Mr Maurie O'Connor, replacing Mr David Morton as the representative from the Department of Veterans' Affairs.

The following representatives were in attendance.

The Royal Australian and New Zealand College of Psychiatrists (RANZCP)

1.	Dr Yvonne White	SPGPPS Chair
2.	Dr Jo Lammersma	
3.	Mr Harry Lovelock	(proxy for RANZCP Observer, Ms Sharon Brownie)

Australian Medical Association (AMA)

4.	Dr Martin Nothling	Chair, SPGPPS Finance Committee
5.	Dr Bill Pring	Observer, Chair SPGPPS Information Strategy Working Group

Royal Australian College of General Practitioners (RACGP)

6.	Dr Brian Kable	

Consumer Representative

7.	Ms Janne McMahon	Chair, National Network of Private Psychiatric Sector Consumers and Carers

Australian Government

8	Ms Suzy Saw	Health Priorities and Suicide Prevention Branch
9	Mr Peter Callanan	Private Health Insurance Branch
10	Mr Maurie O'Connor	Department of Veterans' Affairs

Private hospitals with psychiatric beds (Hospitals)

12.	Ms Moira Munro	SPGPPS Deputy Chair
13.	Ms Carole Turnbull	Hospital Representative

Private health insurance funds that pay benefits for psychiatric care (Health Funds)

14.	Mr Brian Osborne	
15.	Mrs Judy Hardy	

SPGPPS Secretariat

16.	Mr Phillip Taylor	SPGPPS Executive Officer, Chair SPGPPS Innovative Models Working Group
17.	Mr Allen Morris–Yates	SPGPPS Principal Information Officer
18.	Ms Bronwen van der Wal	SPGPPS Administrative Officer

Apologies

1.	Ms Sharon Brownie	RANZCP Observer
2.	Ms Ruth Carson	SPGPPS Carer Representative

Invited Guests

1. Professor John Saunders

1.2. REPORT OF THE 39TH SPGPPS MEETING

Following points of clarification, the Meeting approved the *Report of the 39th SPGPPS Meeting* held on 18 March 2005 in Adelaide, South Australia.

RESOLVED (OSBORNE/MCMAHON)

That the Strategic Planning Group For Private Psychiatric Services (SPGPPS) approves and adopts the Report of the 39th SPGPPS Meeting, held on 18 March 2005 in Adelaide, as a true and accurate record of proceedings, and directs that the Report be made available on the

SPGPPS website.

1.3. PROGRESS REPORT ON ACTIONS ARISING FROM THE 39TH SPGPPS MEETING

The SPGPPS noted and updated the following Table of Progress on Actions Arising from the 39th SPGPPS Meeting.

	Agenda Items	Action Officer(s)	Status
	Report on the 39th SPGPPS Meeting		
➢	Draft and circulate report of 39th Meeting for comment	Secretariat	Done
➢	Revise Report based on comments received and prepare final	Secretariat	Done
➢	Agenda Item 40th SPGPPS Meeting	Secretariat	Done
2	Report on the 38th SPGPPS Meeting		
➢	Post Report on the SPGPPS website @ spgpps.com.au	Secretariat	Done
2.1	SPGPPS Finance Committee (FC)		
➢	Direct AMA to carry forward the 2004 SPGPPS surplus of $8,658 to SPGPPS 2005 Budget	Secretariat	Done
➢	Direct AMA to use CDMS 2004 surplus of $29,740 to cover CDMS overspend of $24,943.	Secretariat	Done
➢	Direct AMA to carry forward the remaining CDMS surplus of $4,797 to CDMS 2005 Budget	Secretariat	Done
➢	Direct AMA to carry forward the 2004 NN surplus of $213 to NN 2005 Budget.	Secretariat	Done
➢	Advise 40th SPGPPS Meeting on 1st Quarter 2005 SPGPPS CDMS and NN budget position	Mr Taylor	Done
➢	Agenda Item 40th SPGPPS Meeting	Secretariat	Done
2.2	The SPGPPS, its CDMS and the NN Progress Report 2004		
➢	Forward Progress Report to *AMA Agreement for Services 2004–2006* signatories.	Secretariat	Done
➢	Post Progress Report on the SPGPPS website at: www.spgpps.com.au.	Secretariat	Done
➢	Draft words promulgating the Progress Report for Stakeholder use.	Secretariat/AMA/RANZCP	Done
➢	SPGPPS stakeholders to promulgate Report in their, newsletters, journals, websites etc.	Stakeholders	Done
➢	Circulate Progress Report to contacts on SPGPPS Database.	Secretariat	Done
3.1	Innovative Models Working Group (IMWG) Report		
➢	Mr Osborne to provide Mr Houghton with information on costs of psychiatric care to Health Funds	Mr Osborne/AHIA MHC	Done
➢	Organise 12th IMWG meeting for 12 April and 13th IMWG Meeting for 15 June 2005	Secretariat	Done
➢	Agenda Item 40th SPGPPS Meeting	Secretariat	Done
3.2	Information Strategy Working Group (ISWG) Report		
➢	Develop proposal to amend HCP to resolve problem with identification of outreach care	Mr Morris–Yates	Done
➢	Seek APHA endorsement for proposal	Mr Mackey	Done
➢	Formally forward endorsed proposal to DoHA for consideration as part of the review of the HCP	Secretariat	Done
➢	Agenda Item 40th SPGPPS Meeting	Secretariat	Done
3.3	National Network Report		
➢	Agenda Item 40th SPGPPS Meeting	Secretariat	Done
4.1	AHMAC NMHWG Report		
➢	Submit comments on *National Action Plan for Safety Priorities in Mental Health* by 4 April 2005	Dr Pring/Mr Mackey	Done
➢	Submit comments on *National Comorbidity Initiative* by 24 March 2005	SPGPPS	Done
➢	Submit comments on *Pathways Of Recovery* by 30 April 2005	SPGPPS	Done
➢	Agenda Item 40th SPGPPS Meeting	Secretariat	Done
4.1.1	Access to Psychiatric Beds		
➢	Provide NMHWG with data on involuntary admission in SA and QLD	Dr White/Mr Taylor	*Pending*
4.1.2	Governmental Inquiries		
➢	Send summary on SPGPPS/CDMS/NN to Senate Select Committee on Mental Health	Dr White/Secretariat	Done
➢	Prepare and send SPGPPS Submission for House of Representative Enquiry into Health Financing	Secretariat	Done
5.4	Psychiatrist's Report		
➢	RANZCP to develop mother and baby guidelines	RANZCP	Done
➢	Follow–up with Health Funds limiting ECT deferred to 39th SPGPPS Meeting	Mr Brian Osborne	*Pending*
➢	Agenda Item 40th SPGPPS Meeting	Secretariat	Done
4.5.2	Medical Reports to Health Funds		
➢	Secretariat to provide a copy of the correspondence to Mr Osborne	Secretariat	Done
➢	Mr Osborn to follow–up correspondence with the RANZCP	Mr Osborne	Done
4.5.3	Health Financing		
➢	Discussion Agenda Item for each appropriate SPGPPS Meeting	Secretariat	*Pending*
4.6	Australian Government Report		
➢	Advise 40th SPGPPS Meeting, if the *Guidelines for Determining Benefits* need review in 2005	SPGPPS	*Pending*
6	Next Meeting (Back–toBack with 7th ISWG Meeting)		
➢	Organise 7th SPGPPS ISWG Meeting for 23 June 2005 @ Brisbane Hilton Hotel	Secretariat	Done
➢	Organise SPGPPS Dinner for 7:00 PM 23 June 2005 @ Lat 27. Bistro	Secretariat	Done
➢	Organise 40th SPGPPS Meeting for 24 June 2005 @ New Farm Clinic, New Farm (Brisbane)	Secretariat	Done
➢	Prepare and circulate Agenda and Papers for 7th ISWG/40th SPGPPS	Secretariat	Done

2. FINANCIAL AND OPERATIONAL MATTERS

2.1 SPGPPS FINANCE COMMITTEE REPORT

The SPGPPS Finance Committee meets to monitor budgetary expenditure, on a quarterly basis, for the SPGPPS, its CDMS, and the National Network of Private Psychiatric Sector Consumers and Carers (National Network). The 6th Finance Committee Meeting was held on Wednesday, 1 June 2005 via teleconference. This meeting constituted the 1st Quarter 2005 meeting of the Finance Committee.

The Chair invited Mr Phillip Taylor to report on the 6th Finance Committee Meeting as the Chair of the Finance Committee, Dr Martin Nothling, was an apology for that meeting.

Mr Taylor reported that the Finance Committee approved the AMA Statement of Income and Expenditure for the first quarter of 2005. The meeting noted that all of the directives given to the AMA following the last (39th) SPGPPS Meeting had been carried out. The surplus funds remaining in the SPGPPS, CDMS and National Network budgets had been carried forward into their respective budgets for 2005. The overspend in the CDMS had been acquitted. The Finance Committee was satisfied with the financial position for the SPGPPS, its CDMS and National Network at the end of the first quarter 2005.

The SPGPPS then passed the following resolutions.

RESOLVED (UNAMIMOUSLY)

1 *That the Strategic Planning Group for Private Psychiatric Services (SPGPPS) notes the draft Report of the 6th SPGPPS Finance Committee Meeting held via teleconference on 1 June 2005.*

2 *That the SPGPPS notes and approves the Statements of Income and Expenditure for the Strategic Planning Group for Private Psychiatric Services (SPGPPS), its Centralised Data Management Service (CDMS) and the National Network for Private Psychiatric Sector Consumers and Carers (National Network), prepared by the Australian Medical Association, as at the 31 March 2005.*

3. SPGPPS SUB–GROUP REPORTS

3.1 THE INNOVATIVE MODELS WORKING GROUP (IMWG) REPORT

The Chair then asked the Meeting to consider the self–explanatory *Draft Report of the 11th IMWG Meeting*, which was held on Monday, 7 February 2005 in Canberra. The Chair of the IMWG, Mr Phillip Taylor, was invited to speak to the report. In opening his address, Mr Taylor provided the following brief overview on the work of the IMWG to date.

In 2003, the SPGPPS established the IMWG to encourage the uptake of innovative models of service delivery and enhance co–ordination of care between general practitioners, psychiatrists and hospitals. IMWG developed a set of *General Principles and Recommendations*, which the SPGPPS endorsed in June 2003 and IMWG progressed for the remainder of 2003 and in 2004.

In 2004, IMWG significantly broadened its Terms of Reference to focus on the merits of different models of service delivery, and to explore the barriers to their uptake in the private sector. To inform this work, SPGPPS stakeholders presented their perspectives on innovative models of funding and service delivery to the SPGPPS throughout 2004.

In 2005, IMWG met in February, analysed the presentations, and agreed to prepare an IMWG Discussion Paper to assess models of funding and service delivery for private psychiatric services using the universal principles derived from experience with the Prospective Payment Model (PPM) in South Australia. IMWG met again on 12 April and June 15 to work on the Discussion Paper.

Mr Taylor reported that the IMWG last met face–to–face in Canberra on June 15, 2005 to further develop the Discussion Paper. At that meeting, it was agreed that the title and the introduction should be revised after the balance of the Paper had been further refined. IMWG members will be taking the Discussion Paper back to their constituencies for comment after it is further developed. Further revisions of the Paper are expected to be forwarded to the Secretariat by 1 August 2005 in preparation for the next face–to–face meeting of the IMWG scheduled for 24 August 2005.

3.1.1 Discussion

Ms Turnbull reported that at the last IMWG meeting, discussion had centred around the funding of service delivery, and the interface between models of funding and the services being delivered. Progress, though slow in this very complex area, is being made. With the deadline for the first draft of the Discussion Paper to be finalised in December 2005, it was felt that IMWG should take that time. Areas that need to be addressed have been identified, consumer and carer perspectives have been revised and the Health Funds have identified a range of funding options for consideration. At this stage, options include the status quo (per diem model), evolution of the current per diem model, a casemix classification per diem model and a bundled payment model (based on the PPM currently in use in South Australia.).

Ms McMahon reported that, initially, the strategy of the IMWG was to identify models of service delivery. Over several meetings, however, the strategy has changed to identifying funding options and assessing those models in light of the models of care identified by consumers and carers as well as consumer and carer preferences such as no significant co–payments. Dr Pring indicated that in the process the IMWG had gone through, the group had learned a lot about each other's perspectives, which can only add to the final product and to respective stakeholder policy processes.

Mr Callanan reported that provided the reporting arrangements to the Private Health Insurance Administration Council (PHIAC) are correctly addressed, there should be no problem with examining funding models that move away from the current per diem model.

Ms Saw indicated that what the DoHA would be looking for in the Discussion Paper is potential quality improvement in terms of improved continuity of care and the capacity to offer a range of services, together with structures and innovative approaches that make better use of the available workforce. Improvement in these two key areas forms the rationale for change in the first place.

Mr Taylor reported that the development of the IMWG Discussion Paper was the subject of an article in the last edition of SPGPPS News to encourage the sector to discuss the issues involved.

RESOLVED (UNAMIOUSLY)

That the Strategic Planning Group For Private Psychiatric Services (SPGPPS) notes the draft report of the 12th SPGPPS Innovative Models Working Group (IMWG) Meeting held on 12 April 2005 via teleconference.

The SPGPPS noted that the next meeting of the IMWG would be held on 24 August 2005.

3.2 THE SPGPPS INFORMATION STRATEGY WORKING GROUP (ISWG) REPORT

The SPGPPS established the ISWG in 2003 to examine the development of an information strategy for the private sector aimed at improving the quality, availability and utilisation of information regarding private sector mental health services. To date, the ISWG has met as follows.

- 1st ISWG Meeting 20 February 2004 (via teleconference)
- 2nd ISWG Meeting 11 March 2004 (Sydney)
- 3rd ISWG Meeting 10 June 2004 (Brisbane)
- 4th ISWG Meeting 9 September 2004 (Perth)
- 5th ISWG Meeting 25 November 2004 (Canberra)
- 6th ISWG Meeting 17 March 2005 (Adelaide)
- 7th ISWG Meeting 23 June 2005 (Brisbane)

The SPGPPS then considered and adopted the Report of the *Report of the Sixth ISWG Meeting*.

> ***RESOLVED (UNANIMOUSLY)***
>
> *That the Strategic Planning Group for Private Psychiatric Services (SPGPPS) adopts Report of the Sixth (6th) Meeting of SPGPPS Information Strategy Working Group, held on 17 March 2005 in Adelaide.*

The Chair reported that the Seventh (7th) ISWG Meeting was held on 23 June 2005 to coincide with this 40th SPGPPS Meeting in Brisbane. The Chair invited the Chair of the ISWG, Dr Bill Pring, to report verbally on that meeting. Dr Pring summarised the main matters discussed at the 7th ISWG Meeting as follows.

- There are processes in place to update the Hospital Casemix Protocol (HCP) that will improve the reporting of episodes of care for day only and outreach patients.
- The SPGPPS's CDMS database is now very large and it will be necessary to replace the current database software with a new system capable of handling large amounts of data and to reprogram all the data and reporting algorithms. However, It will not be possible to implement this change until 2007.
- The APHA Psychiatric Sub–committee has responded to the proposed *alternative model for the provision of refresher and advanced training for participating Hospitals*, prepared by Mr Morris–Yates, and acknowledged that training was important. While the Sub–committee had supported the proposed alternative model, it had agreed that this training was not a priority over the next sixth months of 2005. Accordingly, the ISWG has adjusted Mr Morris–Yates work schedule to rescheduled the provision of refresher and advanced training for participating Hospitals from 2005 to 2006.
- The ISWG considered the risk strategies in place for the CDMS, particularly in relation to the unforeseen absence of Mr Morris–Yates. The ISWG has concluded that "key Person" insurance was a possible solution and is investigating this further.
- A further meeting will be held in Brisbane between members of the ISWG, Ms Ruth Catchpole, Mental Health Unit, Queensland Health, Ms Fiona Davidson, Project Officer, Queensland Health, and Ms Helen Connor, consumer representative for Queensland public sector, and Ms Suzy Saw, on Tuesday, 5 July 2005. The purpose of the meeting will be to further discuss the participation of the public sector in the pilot of NRI/MHSIP Inpatient Consumer Survey originally conceived for pilot in private hospital–based mental health services. The Mental Health Unit of Queensland

Health has indicated that they have identified a number of their integrated mental health services that wish to participate and have the capacity to do so effectively. The ISWG reviewed and amended Mr Morris–Yates current Work Plan for 2005 and 2006.

The SPGPPS noted that the next meeting of the ISWG will be held on Thursday, 6 October 2005, to coincide with the next (41st) SPGPPS Meeting in Melbourne.

3.3 THE SUBSTANCE ABUSE AND DEPENDENCY WORKING GROUP REPORT

The Chair reported that the SPGPPS has previously expressed serious concern over the statistics generated by the CDMS that show that 23.7% of all mental health patients either had a principal or secondary diagnosis of substance abuse disorder.

This matter was referred to the IMWG for it to investigate and advise SPGPPS on the treatment and care of substance abuse and dependency, in respect of both alcohol and other drugs in the private sector.

IMWG advised that this would be a complex and potentially costly task. Additional specialist expertise in the area of the treatment of substance abuse and dependency would be required and the work would take at least 12–18 months to complete.

In September 2003, the SPGPPS agreed that this work should proceed and the Substance Abuse and Dependency Working Group (SDWG) was established.

The Chair then drew attention of the meeting to the following background on this working group.

3.3.1 Background on SDWG Activity 2003–2005

SDWG first met on 24 November 2003 and decided that, given the complexities of the issues involved, several further meetings would be required to determine an appropriate way forward. As a first step, SDWG agreed to invite Ms Fiona Shand to attend and address the 36th SPGPPS Meeting in June 2004 on the development of the National Drug and Alcohol Research Centre (NDARC) *Guidelines for the Treatment of Alcohol Problems*.

In the interim, the SPGPPS Secretariat obtained and published the schedule of workshops for the NDARC Guidelines in the first edition of *SPGPPS News* for 2004. On 12 March 2004, the 35th SPGPPS Meeting and Planning Day agreed that SDWG should reconvene to review its membership and further progress its recommendations following Ms Shand's presentation.

Following Ms Shand's presentation, SDWG met on 4 August 2004 and agreed that it had now largely completed the task of informing the private sector on treatment guidelines for alcohol. The *Guidelines for the Treatment of Alcohol Problems* were distributed to Hospitals participating in the CDMS and had been further promoted by through the SPGPPS Newsletter.

At the 38th SPGPPS Meeting held on 26 November 2004, the Chair of SDWG, Mr David Morton, reported that there did not seem to be any further specific task now for the SDWG to perform. In response, the RANZCP indicated that there seemed to be little knowledge about co–morbidity issues particularly in the private sector and there could be an educational role for SDWG. This is important because SDWG could have a role in disseminating the outcomes of activity in this area, which includes the following.

- There is a national project being funded by the Alcohol, Education and Rehabilitation Foundation over the next two years through the Australian Divisions of General

Practice (ADGP) to improve the primary care response to people with alcohol misuse and mental illness co–morbidity, particularly anxiety.

- The DVA *Alcohol Treatment Guidelines for Veterans* have been released. Copies were of these Guidelines were tabled at this 40th SPGPPS Meeting by Mr Maurie O'Conner.
- The Drug and Alcohol Section of RANZCP is active in this area.
- The Australian Government mental health policy foreshadowed a refocusing of activity in this area towards a greater emphasis on co–morbidity issues especially among young people.
- The issue of co–morbidity was looked at under the ACE Mental Health Project. Of interest, the project came to the conclusion that there was insufficient evidence or research to direct best clinical practice in the treatment of co–morbid conditions

The Chair reported that the 38th SPGPPS Meeting had agreed that promoting the screening for substance abuse and education on co–morbidity issues was important. To further that agenda, the SPGPPS invited Professor John Saunders from the Centre for Drug and Alcohol Studies, Department of Psychiatry, School of Medicine, University of Queensland, and the Alcohol and Drug Service, Royal Brisbane and Women's Hospital to address this 40th SPGPPS Meeting.

The Chair then welcomed Professor Saunders to the Meeting.

3.3.2 Substance Use Disorders and the Private Hospital Role

Professor Saunders commenced the presentation with an overview of substance abuse in Australia and it was noted that the conception of substance use disorder has changed considerably over the years.

The substances most commonly misused, in order of prevalence, are now as follows.

1. Alcohol
2. Sedative–hypnotics (e.g. Valium)
3. Heroin and other opiates
4. Prescribed opioids
5. Cannabis
6. Amphetamines
7. Cocaine and other stimulants
8. Ecstasy
9. Hallucinogens
10. Inhalants

There are essentially three pharmacological classes, the central nervous system (CNS) depressants, headed by alcohol and running down the list to cannabis, the most common substances misused, followed by the three psycho–stimulants and lastly the two hallucinogens including LSD. The latter are uncommonly used and rarely seen in the private hospital system.

Table 1: Substance Use in the Australian General Population: Findings from the recent National Drug Strategy Household Surveys

	Lifetime Usage (%)				% Change
	1993	1995	1998	2001	
Alcohol	88.0	88.7	89.6	90.4	+1.0%
Tobacco	–	–	50.8	49.4	–3.0%
Cannabis	34.7	31.1	39.3	33.1	–16.0%
Heroin	1.7	1.4	2.2	1.6	–27.0%
Amphetamines	5.4	5.8	8.8	8.9	+1.0%
Cocaine	2.5	3.4	4.3	4.9	+2.0%
Any illicit drug	38.9	39.3	46.0	37.7	–18..0%
Injected illicit drugs	1.9	1.3	2.1	1.8	–14.0%

Table 2: Substance Use in the Australian General Population: Findings from the recent National Drug Strategy Household Surveys

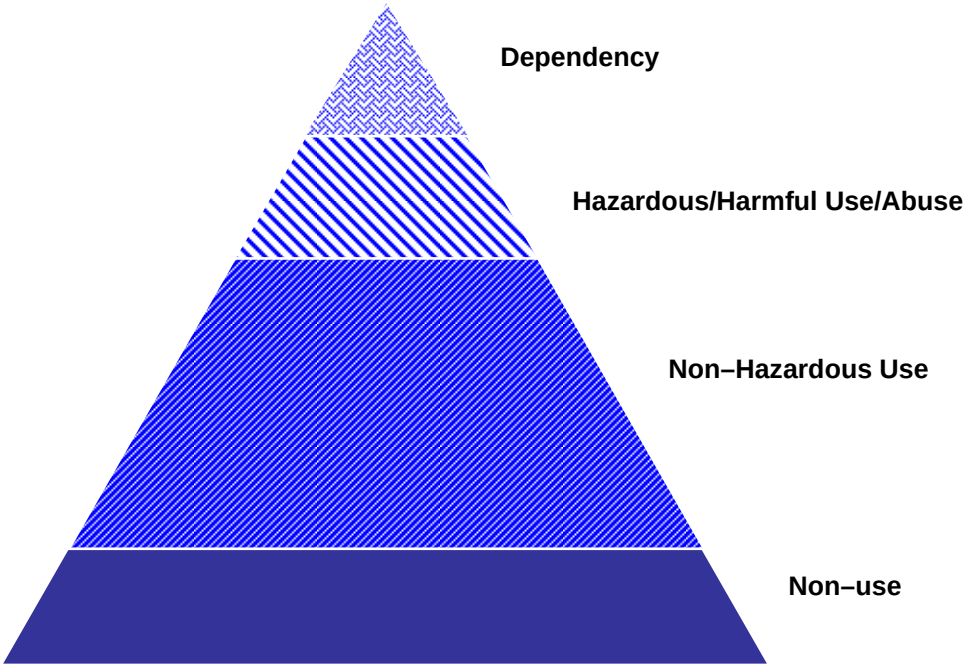
	Use in Past Year				% Change 1998 – 2001
	1993	1995	1998	2001	
Alcohol	73.0	78.3	80.7	82.4	+2%
Tobacco	–	–	22.7	19.5	–14%
Cannabis	12.7	13.2	17.9	12.9	–28%
Heroin	0.2	0.4	0.8	0.2	–75%
Amphetamines	2.0	2.1	3.7	3.4	–8%
Cocaine	0.5	1.0	1.4	1.3	–7%
Any illicit drug	14.0	17.0	22.0	16.9	–23%
Injected illicit drugs	0.5	0.6	0.8	0.6	–25%

Professor Saunders explained that every three years, the Australian Bureau of Statistics (ABS) conducts a national randomised survey, via interview, of households. These surveys provide reliable data of the state of substance abuse. What can be seen from the data is that through the 1990's there was a steady increase in the use of a range of illicit drugs, in particular, heroin.

Heroin use, however, has declined over the last five years. Use was 0.2% in 2001 and the 2004 figures, which are not shown, are similar. Amphetamines are currently much more common. Though this is a national survey and does not translate directly to the patients seen in practice, it raises awareness of the changing pattern of drug usage and allows for better planning of services.

Over the 1990's there was an epidemic of heroin related problems including overdose and dependency. What is seen now are the mental health complications associated with amphetamine usage.

The Spectrum of Use and Misuse



Over the last century there has been an array of diverse opinion about what constitutes substance abuse disorder. It is now recognised that there is a spectrum of substance use and misuse of all psycho–active substances (refer to Figure 1 above).

For most substances most of the population will be absent. A number, using some substances like alcohol, will be in the low risk category. A smaller number will use certain substances in ways that are known to have negative consequences. At the top of pyramid are those with a definable clinical syndrome of dependency, which acts in many ways like a disease process.

The Dependence Syndrome

Dependence syndrome is essentially a condition that occurs as the result of an initial period of repeated substance use. It is associated with neurochemical changes, which sets up a syndrome with a 'life of its own'. It is a psychobiological syndrome, which comprises an inner "drive" to take alcohol or drugs regardless of harmful consequences, preoccupation with substance use, and sometimes withdrawal symptoms. The criteria are set out below. Three of the following elements occurring repeatedly for one year are necessary for the diagnosis according to International Classification of Diseases (ICD–10).

- Impaired control over substance use.
- A strong desire to take the particular substance.
- Preoccupation with substance use (given greater priority than other activities).
- Increased tolerance.
- Withdrawal symptoms on cessation of substance use, or relief of withdrawal symptoms by further use.
- Continuation of use despite harmful effects.

It amounts to a powerful internal driving force.

Dependence and the Reinstatement Phenomenon

Professor Saunders explained in terms of alcohol intake and severity of dependence. It implications are that if a person is physically dependent on alcohol to the extent that they repeatedly (more than twice per week) suffer withdrawal symptoms, then they would be best advised to abstain, rather than attempt moderated or controlled drinking.

The Impact of Neuroscientific Knowledge

Over the last fifteen to twenty years there has been a major investment in neuro–scientific research into substance abuse. Arising from this research it is now known that substance dependence syndromes have profound biological underpinnings. What happens is a resetting of the dopamine reward pathways in the midbrain.

The biological mechanisms of substance dependence identified are nuclei in the mid–brain concerned with reward and reinforcement, including the:

- ventral tegmental nucleus; and
- nucleus accumbens.

The changes in neurotransmission are multiple, deep–seated and lingering. Some of these changes last for as long as the lifespan of the individual. The Syndromes can be chronic and quickly re–activated upon further exposure to the substance, which does not represent a relapse due to choice, but as a consequence of biological drives. Genetic factors account for around 50% of the reason why some people develop substance abuse disorder.

Alcohol's Effects on Opioid Neurotransmission

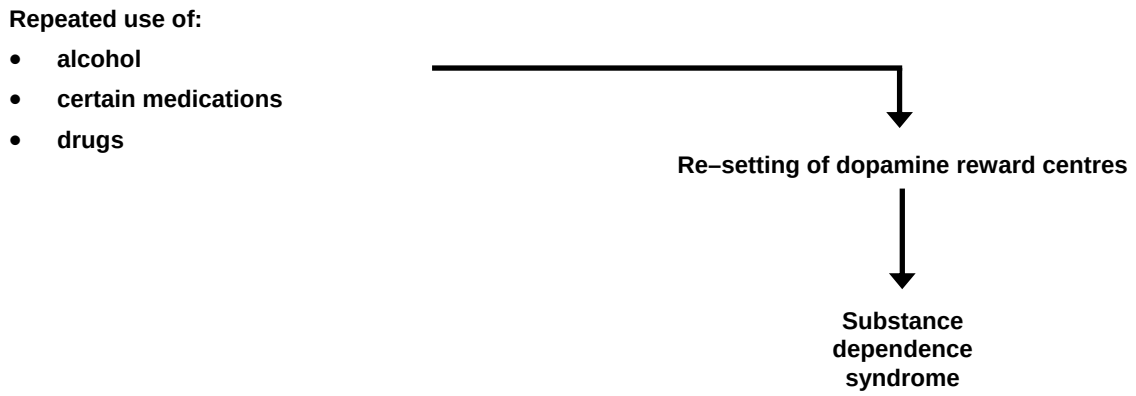
Professor Saunders explained the workings of the dopamine reward pathways in the brain. Alcohol and the benzodiazepines have their primary effect on the GABA neurone. The GABA neurone activates the dopaminergic neurone, which releases dopamine. For most psychogenic substances, a final common pathway, which result in reinforcement of substance use is mediated through dopamine pathways. Other neuronal pathways are involved, which influence the rate at which a Dependence Syndrome will develop. Dopamine is also instrumental in inducing neuronal plasticity. In many with substance dependence syndromes, the behaviours become *hard–wired*.

Professor Saunders emphasised that as a result of the research, clinicians are aware that substance abuse disorders are profoundly biologically mediated processes, not behaviours of choice, and clinicians are increasingly able to define what those processes are and therefore what can be done about them.

Modern Understanding of Substance Use Disorders

There is a spectrum of these disorders. At the severe end of the spectrum is the dependence syndrome. This is a clinical disorder, with common features across all psychoactive substances with abuse potential. It has biological, genetic, psychological, and societal causes. The Dependence Syndrome concept has been accepted by the Diagnostic and Statistical Manual of Mental Disorders (DSM) and the ICD. People entering Hospitals with a substance abuse disorder almost always have a dependence syndrome. There are people with a primary psychiatric disorder who have a significant substance use problem, which is not necessarily dependence.

Mechanisms of Substance Dependence



Individual Vulnerability

No one is immune to developing dependence syndrome if exposed to sufficient amounts of the substance over a sufficient length of time. Some, however, are more vulnerable than others. Individual susceptibility factors include the following.

Genetic Factors – There is evidence of a genetic predisposition to substance use and the development of dependence. It is thought that there is some correlation between a predisposition to substance dependence and creativity.

Modelling of Behaviour – Exposure to use of psychoactive substances by family members does influence the development of dependency, though not as powerfully as the genetic factors.

Abuse in Childhood – It is known that emotional deprivation in childhood and physical and sexual abuse have a profound effect on increasing vulnerability to substance dependence. About 1 in 4 patients with substance dependency have a history of some form of abuse.

Trauma – from War or in civilian life as an adult is a significant risk factor for the development of a substance dependence syndrome. Vietnam veterans are one well–recognised group with severe trauma and substance abuse disorders.

Psychiatric Disorders – Affective disorders, particularly bipolar disorder, anxiety disorders and schizophrenia increase the risk of developing a substance dependency. Bipolar disorder contributes to a six–fold increased risk compared to the general community. With schizophrenia, the risk of having a substance dependence syndrome is 4–5 times that of the general population. The situation is complicated. Most of the psychiatric syndromes seen with substance abuse are secondary to the substance abuse disorder. About 20% of the substance abuse population will have a significant, primary, psychiatric disorder underlying the substance abuse.

Personality Traits – There is no evidence that personality disorders contribute significantly to the development of substance abuse disorder though there are some personality features such as impulsivity and rebelliousness that increase the risk of substance abuse in some people. Conduct disorder in children is regarded as a risk factor.

In approximately half the people with a substance abuse disorder, no predisposing factor can be identified. They appear to have slipped into a repeated usage pattern and developed a dependence syndrome.

Environmental Factors

The environmental factors associated with substance dependency are as follows.

- *Availability of Substance* – legality, cost, physical availability
- *Cultural acceptance*
  - The degree to which substance is socially sanctioned
  - Traditional practices
  - Acceptance of use and encouragement by peer group
- *Employment*
  - Certain occupational groups are associated with drug and alcohol use and misuse
  - Unemployment a risk factor

Tertiary Interventions for Substance Use Disorders

Initially, assessment and advice is provided. Detoxification and other management of the acute presentation are required in about 50–60% of patients. Typically, it constitutes the first few days of a treatment program. There is a range of evidence based psychological and pharmacological interventions available. Substitution represents one of the pharmacological approaches. In recent years, the focus on pharmacological intervention has increased and this is consistent with what is now known of the biological basis for substance abuse disorders.

Treatments for Alcohol Misuse: What is Best Practice?

Hazardous alcohol use and alcohol abuse
Not many people will be seen in the private hospital setting with this condition as the primary disorder, but it can be present as co–morbid to an affective disorder. Treatment strategies appropriate for this group include.

- Brief interventions, which will reduce hazardous use by 30–40%.
- There is good evidence for the effectiveness of cognitive–behaviour therapy and motivational enhancement therapy for this group of patients.
- Correspondence–based and Internet therapies may be possible in the future.

Alcohol Dependence Syndrome
Patients with alcohol dependence syndrome constitute the bulk of the substance abuse population spectrum seen in private hospitals. Evidence based practices include the following.

- Cognitive–behaviour therapy
- Motivational enhancement therapy
- Twelve–step approaches have been vindicated in recent years as effective interventions.

Pharmacological treatments have increased and a range of medications are available. The two principal ones, acamprosate and naltrexone, reduce relapse rates by 20–50%. There is also supervised disulfiram.

Treatments for Alcohol Misuse: What is <u>NOT</u> Best Practice?

Alcohol dependence

There is unfortunately, a range of interventions commonly available for which there is no good evidence that the intervention is effective. These include.

- Analytic psychotherapy has been shown to be worse than doing nothing.
- Confrontational therapy was an approach that was thought to make the reality of the situation clear to the patient. Evidence indicates that people react badly to this approach and the outcomes are worse than doing nothing.
- Supportive counselling, though readily available, has not been proven effective.
- Most forms of aversion therapy, cue exposure therapy and hypnosis are not effective.
- There is no evidence in favour of the use of benzodiazepines and related drugs after the detoxification period or for the use of anti–depressants (TCAs and SSRIs), though commonly prescribed.

Professor Saunders then used the following matrix

Treatments for Alcohol Misuse		
Best practice	**Bad practice**	**Available**
Brief interventions CBT MET 12–step approaches Acamprosate Naltrexone		Just say no! CBT (limited) MET (limited) 12–step approaches Acamprosate (limited, if at all) Naltrexone (limited)
	Analytic psychotherapy Confrontation therapy Supportive counselling Aversion therapy Hypnosis Benzodiazepines (post–detox) Anti–depressants Residential treatment	Analytic psychotherapy Confrontation therapy Supportive counselling Benzodiazepines (post–detox) Anti–depressants

There is a major disjunction between what is shown by the research to be best practice and what is done 'in practice'. It is very difficult to arrange for cognitive–behaviour therapy (CBT) or motivational enhancement therapy MET, unless the patient is privately insured and the health insurance carried covers for psychologist fees. There is massive under–access of pharmacological approaches, whereas a range of bad practices is readily available in the current treatment system. Some of these are relatively old approaches.

Alcohol Dependence in Australia

Professor Saunders summarised the features of alcohol dependence in Australia as follows.

- In a population of 20 million there are 515,000 alcohol dependent people.
- This is a common condition, which affects people from all walks of life.
- There is now a large evidence base underpinning the provision of effective treatment.
- But what treatment is provided and how much is provided?

GPs' use of Pharmacotherapies for Alcohol Dependence

Professor Saunders cited the following study showing the very low rates of pharmacological intervention as evidence for the current problems with the current treatment delivery system.

> *Based on the number of scripts for these drugs filled in Australia in 2001, and assuming 50% compliance with the recommended treatment periods, we estimated that 4602 people took acamprosate and 8899 naltrexone in that year. This is equivalent to a maximum of about 3% of alcohol–dependent individuals taking either drug (13 501 individuals using either drug/512 935 alcohol–dependent individuals).*
>
> Doran et al (2003)

Specialists' Use of Pharmacotherapies for Alcohol Dependence

Professor Saunders reported that currently at the Alcohol and Drug Service at the Royal Brisbane and Women's Hospital, 80–90% of inpatients with alcohol dependence are discharged on acamprosate or naltrexone, and 80% of outpatients at Biala Alcohol and Drug Service, at The Prince Charles Hospital are treated with acamprosate or naltrexone.

A survey of members of the American Society of Addiction Medicine and the American Academy of Addiction Psychiatry, which involved 1,388 questionnaires being returned, representing a 65% response rate (Mark et al 2003), showed that the following percentage of of patients were treated with a medication.

% of Patients Treated with a Medication

- naltrexone 13%
- acamprosate n/a
- disulfiram 9%
- benzodiazepines 11%
- anti–depressants 46%

It is notable that for pharmacological interventions such as naltrexone, the use of which has a good evidence base, the rate of use is low – 13%, compared to the widespread use of anti depressants, which are probably ineffective.

Treatments for Other Substance Misuse: What is Known?

Cannabis Dependence

This is a growing problem and one that treatment programs should target. Hospitals are seeing a raft of mental health complications associated with cannabis use. It is known that cannabis use in late adolescence/early twenties is followed by a four to five fold increase in the prevalence of affective disorders and schizophrenia.

Cognitive–behaviour therapy is promising but there is limited evidence. Cannabinoid antagonists are currently being trialled.

Heroin Dependence

Substitution treatment – There is solid evidence for the effectiveness of methadone and buprenorphine in reducing harm and deaths.

Antagonist pharmacological treatments – There is some evidence for the effectiveness of naltrexone for highly motivated clients with good social support.

Rehabilitation and supportive approaches – There are good individual outcomes, but the attrition rate is high and the approach is unpopular with many.

Psycho–stimulant Dependence

- Modest benefits can be gained from cognitive–behaviour therapy (4 sessions plus). There is a clear benefit from twelve–step facilitation, but it is culture dependent.
- There is no established pharmacotherapy for psychostimulant amphetamine dependence, but there are some trials attesting to the moderate effectiveness of disulfiram and medafinil. Dexamphetamine substitution is also a useful modality with this population.
- Serotonin reuptake inhibitors relieve depression in the first 4–6 weeks, but have no long term benefit

Currently there is no information on assessing community needs. Professor Saunders reported that in Victoria about 15 years ago there was an attempt to determine the numbers of private hospital beds required for detoxification. The Royal Australian College of Physicians, Chapter of Addiction Medicine is working on this issue, and in particular, trying to identify the numbers of specialist practitioners that are needed in addiction medicine and psychiatry.

Although there is no way to calculate the need for service provision, experience has shown that there is significant under–provision of services. A growth in provision of services could be expected over the next 5–10 years.

The Reach of Treatment

There is massive under–availability of treatment, particularly for alcohol dependence, cannabis dependence, psycho–stimulant dependence and those dependencies co–morbid with psychiatric disorders. On the other hand, there is very good provision on an ambulatory basis for patients with heroin dependence.

Treatment offered is often inappropriate. Out patient treatments are well supported by the evidence base. However, the average number of therapy sessions attended in ambulatory services is 2.2. This amounts to roughly an assessment session followed by one follow–up session.

Professor Saunders indicated that, a private hospital program is a *delivery mechanism*, not a *treatment modality* where, in engaging the person in treatment, in a structured program in an in–patient setting, the provision of evidence–based therapy is achieved in a way that is difficult to achieve in ambulatory settings.

Providing Treatment – The Private Hospital Program

People with substance dependency syndromes need engagement in their treatment. They typically do not seek treatment. They may experience problems but do not recognise the source and there may be pressure from colleagues and family to seek treatment. In an ambulatory system, the window for engagement is more limited.

Professor Saunders indicated that the typical private hospital program lasts between 1 and 3 weeks. The first week involves detoxification and if there is no co–morbid condition or other complicating factor, they graduate to a day program. Those with physical or psychiatric co–morbidities require another week and those whose conditions are very complex may require longer. A proportion (10–15%) may require even longer (5–6 weeks).

A program would have the following components.

- In the first few days information and advice is provided to help the patient gain a deeper understanding of their disorder.
- Detoxification is provided, which is important because an untreated withdrawal syndrome from certain substances has a significant morbidity and mortality. There are well established protocols.
- On Day 2 or 3 pharmacological intervention is commenced.
- A structured psychological therapy program is provided focusing on developing problem solving strategies aimed at identifying high–risk situations and helping patients to develop rapid response strategies to deal with those situations. This part of the program is instituted at Day 3 or 4 and runs for the rest of the program.
- Treatment of underlying and associated disorders is part of the program.
- Support programs for families are provided either directly or through referral.
- Self–help and after care programs are encouraged.

Professor Saunders indicated that the more we know about substance abuse and dependency syndromes, the more important it is to engage people in evidence–based treatment. There is a role for the private hospital sector in providing robust treatment programs.

Dr White thanked Professor Saunders for his excellent presentation and opened the floor for discussion.

3.3.2.1 Discussion

Ms Turnbull requested clarification of the assessment and referral phase of the program and the apparent contradiction in having good evidence for effective out–patient programs yet the psychological component is run on an in–patient basis. Professor Saunders explained that the attrition rate is considerable for ambulatory care with this population, but much less if the patient can be engaged first in the treatment on an in–patient basis and then proceed to a day program. Referrals generally come from physicians and general practitioners, but mostly from psychiatrists. Assessment is either by a consultant psychiatrist in their rooms or by telephone if they come from a considerable distance. Additionally, there are nursing and often psychological assessments. There are various assessment proformas available. These are useful in settings which use large numbers of temporary or casual staff to ensure consistency. In terms of exclusion, professor Saunders related that in his experience, patients with a primary diagnosis of heroin dependence are not admitted, because of behavioural problems and are better managed on an out–patient basis.

Dr Nothling reported that in his experience of patients with substance abuse co–morbid with a psychiatric condition, there were two groups of patients, one with a known disorder for example, who have been drinking heavily. After detoxification, they resume treatment. The other group are a previously unknown quantity, presenting as depressed with an alcohol problem, who after detoxification lose all signs of a psychiatric condition. Dr Mark Schukit of San Diego advised that patients presenting with apparent psychiatric conditions co–morbid with substance abuse should undergo detoxification and nothing else for ten days. Within that time the apparent psychiatric condition resolves in 90% of these patients. Professor Saunders agreed with that protocol, though he placed the number of patients without a true psychiatric disorder closer to 70–80%. There is a group whose psychological state apparently regresses during detoxification temporarily. Another group demonstrates a secondary, lingering psychiatric disorder, which tend to run a course of a

few months to a year. This latter group are termed to have a post detoxification affective or anxiety disorder. Professor Saunders advised that introducing antidepressants At Day 2 of detoxification would result in massive over treatment and what is emerging now from the research is that there are sub–groups for whom the prognosis is worse if they are put on antidepressants, specifically young men between the ages of 18 and 35–40. This is why 47% of physicians in the US prescribing antidepressants is of great concern. Ms Judy Hardy indicated that Health Funds, through some of their rules, have inadvertently encouraged such practices. Health Funds need assistance in developing guidelines that encourage the use of evidence–based practices.

Dr Kable questioned whether the prevalence of psychiatric disorder co–morbid with substance abuse was higher in young people than in the general population. Professor Saunders clarified that the prevalence was likely to be higher in a clinical population because the effect of the disorders tended to enhance each other and promote the seeking of help leading to an increased rate of diagnosis. In epidemiological surveys there is no association between a primary mental health disorder and young people compared to middle–aged people. It is known that different services attract different populations.

Dr Nothling asked if there was any basic screening test, which correlates with a person's drinking level given the common problem of treating what looks to be an affective disorder, but there is also a drinking problem. Dr Nothling indicated that the carbohydrate deficient transferrin test seemed to correlate reasonably well to patients reported alcohol intake. Professor Saunders reported that self–report by the patient appeared to be as sensitive as any biological test for assessing alcohol intake. The problem with biological tests is that only 50% of alcohol dependent people will show any abnormality. Most commonly these are the liver enzymes. If the population is hazardous drinking rather than dependent, then no test will identify more than a quarter. The value of biological tests lies in their use in monitoring progress.

On the question of the under prescription of pharmacological agents, Professor Saunders explained that they had been working vigorously with GPs and the Australian Divisions of General Practice to increase awareness of pharmacotherapy for substance abuse disorders. This has not been entirely successful. More recently, they have been supporting the pharmaceutical companies in 'direct to consumer' promotion of programs. One of the big developments in the area of treatment for substance abuse is the provision of therapy through website intervention.

Dr Nothling reported that Dr Mark Schukit would be the keynote speaker at a major conference on drug and alcohol in Sydney in September 2006.

3.3.3 Future of SDWG

The SPGPPS considered the issues raised by Professor Saunders and recommended that the SDWG be reconvened to undertake the following.

1 Consider how best to promote the best practice scenarios outlined in the Professor Saunders presentation to the 40th SPGPPS Meeting.

2 Review the *Guidelines for Determining Benefits for Health Insurance Purposes for Private Patient Hospital–based Mental Health Care* (Guidelines) and identify any Health Fund restrictions that might impact on best practice in the treatment of people with drug dependency, with a view to developing an appropriate subsection for these Guidelines.

3 Consider the best way to disseminate the information from Professor Saunders presentation, with consideration of the reality that many practitioners have little exposure to information about drug and alcohol treatment.

The meeting agreed that the SDWG should meet shortly via teleconference. Mr O'Connor and Mr Taylor will liase on the format for this meeting. The Chair advised that if necessary following the deliberations of the SDWG, a teleconference of the SPGPPS Executive could be convened.

RESOLVED

That the Strategic Planning Group For Private Psychiatric Services (SPGPPS, directs its Substance Abuse and Dependency Working Group (SDWG) to reconvene and undertake the following.

1 Consider how best to promote the best practice scenarios outlined in the presentation titled, Substance Abuse and the Role of the Private Hospital, given by Professor John Saunders to the 40th SPGPPS Meeting held on 24 June 2005 in Brisbane.

2 Consider the Guidelines for Determining Benefits for Health Insurance Purposes for Private Patient Hospital–based Mental Health Care (Guidelines) with a view to developing an appropriate subsection of these Guidelines on best practice in the diagnosis and treatment of people with substance abuse and dependency, recognising that there is often a high comorbidity between substance use and psychiatric disorders.

3 Consider the best way to disseminate the information from Professor Saunder's presentation, with consideration of the reality that many practitioners have little exposure to information about drug and alcohol treatment.

3.4. NATIONAL NETWORK REPORT

The Chair reported that the Tenth (10th) National Network for Private Psychiatric Sector Consumers and Carers (National Network) Meeting was held at RANZCP Headquarters in Melbourne on 21 and 22 February 2005. Dr White then invited the Chair of the National Network, Ms Janne McMahon, to report on that Meeting.

Ms McMahon reported that the SPGPPS carer representative, Ms Ruth Carson has been elected co–chair of the National Consumer and Carer Forum (NCCF). The South Australian Co–ordinator for the National Network, Ms Marjorie Smith, was named in the Australia Day Honours List for her services in promoting carer issues.

Ms McMahon reported that the National Network had put in four submissions to the following enquiries.

1 Senate Select Committee Enquiry into Mental Health.

2 Review of the Medicare and Pharmaceutical Benefits Programs Privacy Guidelines.

3 Human Rights and Equal Opportunity Commission National Enquiry into Disability and Employment.

4 House of Representatives Standing Committee on Health and Ageing Inquiry into Health Financing.

Ms McMahon reported that the collated results of the consultation process for the Consumer Perceptions of Care (CPoC) Measure have been circulated to the National Network. The Network suggested a number of changes. The SPGPPS Principal Information Officer, Mr Allen Morris–Yates vetted the National Network's review of the CPoC so that the proposed changes do not invalidate the measure. Ms McMahon reported that an informal meeting has been scheduled for 7 July 2005 in Brisbane to discuss the measure between representatives of Queensland Health, Mr Morris–Yates, Ms Helen Connor, Chair, Mental Health Consumer Network, Ms Munro, Ms Suzie Saw and herself. The SPGPPS noted that the Hospitals were of major assistance to the National Network in its consultation process.

Ms McMahon reported that the Network is fortunate that two of its co–ordinators are trained facilitators. At the 10th Meeting of the Network, there was general agreement that there was a need for training for consumers and carers in their advocacy. The National Network will undertake a needs analysis of consumer and carer training at the next face–to–face meeting in August 2005.

Ms McMahon reported that the TheMHS conference will be held in Adelaide this year. To promote the work of the Network more widely, Ms McMahon had enquired into the costs of running a booth at the TheMHS conference at $100 a day and the production of a freestanding banner at a cost of $850. The background of the banner can be changed and can be used for promotion activities involving the SPGPPS, the CDMS and the National Network. The SPGPPS unanimously agreed that the cost of the banner should be split equally between the budgets of the SPGPPS, its CDMS and the National Network. Further backgrounds for the banner could be purchased as needed. Dr Kable indicated that the Mental Health Standards Collaboration incorporates a document on the consumer and carer perspective in the preparation and delivery of the training program for GPs, which is available from their website.

At the suggestion of the SPGPPS Principal Information Officer, the SPGPPS also agreed to underwrite the cost of an ADSL broadband internet connection for Ms McMahon to facilitate her work for the National Network and the SPGPPS.

RESOLVED

That the Strategic Planning Group For Private Psychiatric Services (SPGPPS) underwrites the cost of an ADSL broadband internet connection for the SPGPPS Consumer Representative, Ms Janne McMahon at her home in Adelaide.

The Chair extended the thanks of the SPGPPS to Ms McMahon for all the work she has done to develop the National Network.

4 STANDING ITEMS

4.1 AHMAC NATIONAL MENTAL HEALTH WORKING GROUP (NMHWG)

At the 39th SPGPPS Meeting, the SPGPPS representative on the NMHWG, Dr Yvonne White, reported on the meeting of the NMHWG held on 7 March 2005 in Auckland, New Zealand, as detailed under Agenda Items 4.1 and 4.1.1 in the *Report of 39th SPGPPS Meeting*.

4.1.1 Out–of–Session Papers

The following out–of–session papers had been circulated to the SPGPPS recently.

1. The *Report of the Evaluation of the National Minimum Data Set for Admitted Patient Mental Health Care*.
2. *Establishment of the National Mental Health Workforce Advisory Committee* (NMHWAC).

Dr White reported that in relation to the NMHWAC, the SPGPPS has asked to have private sector representation on this committee. At this stage, it is not known whether this representation will be possible. The NMHWG has asked whether the SPGPPS would support the formation of this sub–committee. Ms Saw indicated that this group will be looking at broad issues and a person knowledgeable about the issues would be preferable. The Chair indicated that there are two aspects to this issue. Sixty percent of mental health consultations take place in private practice and the private sector has twenty–one percent of the bed numbers. Ms Saw suggested that the SPGPPS could request to have both psychiatrists and Hospitals represented. Ms Saw reported that this group would be taking forward the large body of work already undertaken in relation to the nursing workforce, practice standards and innovative practice. The meeting agreed that the Chair and Mr Taylor would take this issue to the next meeting of the AHMAC NMHWG requesting that a Hospital representative and a RANZCP representative be appointed.

RESOLVED

That the Strategic Planning Group for Private Psychiatric Services (SPGPPS) requests the AHMAC National Mental Health Working Group to appoint a Hospital representative and a representative from the Royal Australian and New Zealand College of Psychiatrists to the National Mental Health Workforce Advisory Committee.

4.1.2 ACCESS TO PSYCHIATRIC BEDS

The SPGPPS had requested Dr White advise the 15 July 2005 NMHWG that the main barriers to changing existing practices with regard to private hospitals being able to take involuntary patients are the differences in mental health acts across Australian States and Territories.

At the last (39th) SPGPPS Meeting it was agreed that the disruption to continuity of care caused by the current situation was a significant issue, particularly given the number of people reportedly affected. Since the 39th meeting, the SPGPPS Information Officer has compiled the following information.

Table 1: Separations from overnight inpatient care with specialised psychiatric care by mental health legal status for the two Jurisdictions (Queensland and Western Australia) within which Private hospitals with psychiatric beds had significant numbers of Involuntary patients in 2002–03.[1]

	QUEENSLAND			WESTERN AUSTRALIA		
	All	Involuntary	%	All	Involuntary	%
Public Psychiatric Hospitals	462	322	69.7%	1,920	1,344	70.0 %
Public Acute Hospitals	17,224	7,582	44.0%	6,381	1,760	27.6 %
All Public	17,686	7904	44.7%	8301	3,104	37.4 %
Private Psychiatric Hospitals	4,832	69	1.4%	2,694	126	4.7%

1. This information has been taken from Table 5.4 on pages 117 and 118 of Australian Institute of Health and Welfare (AIHW) *Mental Health Services in Australia 2002–03*. Canberra: AIHW (Mental Health Series no. 6).

Dr White reported that the recommendation to be submitted to the NMHWG was as follows.

> THE SPGPPS REQUESTS THAT, WHEN STATE AND TERRITORY JURISDICTIONS REVIEW THEIR RESPECTIVE MENTAL HEALTH ACTS, THEY CONSIDER REMOVING ANY BARRIERS THAT PREVENT PRIVATE HOSPITALS FROM BEING ABLE TO TAKE INVOLUNTARY PATIENTS. THE DISRUPTION TO CONTINUITY OF CARE CAUSED BY THE CURRENT SITUATION, WHEREBY LEGISLATION IN SOME JURISDICTIONS EXCLUDES PRIVATE HOSPITALS FROM ACCEPTING INVOLUNTARY PATIENTS, IS A SIGNIFICANT ISSUE, GIVEN THE NUMBERS OF PEOPLE AFFECTED

Mr Osborne indicated that Health Funds had, at one point, looked at the position of involuntary patients in relation to the patient charter of rights and responsibilities. The second issue is that even though their involuntary status is decided by the State, the cost is picked up by the Health Fund. Ms Saw suggested that there are few cases where patients cannot exercise a choice and could be said to have done so proactively by taking out private health insurance. Ms McMahon reported that the need for legislative change to bring some conformity to the legislation governing involuntary patients in the various jurisdictions and to allow consumers to exercise their choice in all jurisdictions had been raised in their submission to the Senate Select Committee on Mental Health.

Ms McMahon felt very strongly that consumers with private health insurance should be able to have access to care in the private sector as involuntary patients.

RESOLVED (UNAMIOUSLY)

That the Strategic Planning Group For Private Psychiatric Services requests that its representative on the AHMAC National Mental Health Working Group (NMHWG), Dr Yvonne White, put the following recommendation to the 15 July 2005 meeting of the NMHWG.

> *"That the SPGPPS requests that, when state and territory jurisdictions review their respective mental health acts, they consider removing any barriers that prevent private hospitals from being able to take involuntary patients. The disruption to continuity of care caused by the current situation, whereby legislation in some jurisdictions excludes private hospitals from accepting involuntary patients, is a significant issue, given the numbers of people affected."*

4.2 HOSPITALS REPORT

Ms Moira Munro reported that the Australian Council on Healthcare Standards (ACHS) had released their *National Report on Health Services and Accreditation Performance 2003 – 2004*. The Report showed that over half of Australia's hospitals have inadequate systems to prevent and review medical errors and ensure patient safety. Since they brought in the new EQuIP standards, the large majority of hospitals are not achieving four year accreditation status. Healthcare facilities in the private sector performed better overall than in the public sector. Of the 342 organisations surveyed in 2004, 14 achieved at least one outstanding achievement (the highest possible). One of those 14 was Toowong Private Hospital in Queensland, which gained its outstanding achievement for consumer participation in health services.

Ms Munro reported that some time ago, APHA were given representation on the ACHS Clinical Indicator Review Committee for mental health indicators. This Committee had its first meeting three weeks ago. Hospitals have received considerable feedback from psychiatrists that one of the Clinical Indicators currently used, *in–patients on two or more*

psychotropic medications at the time of discharge, is no longer appropriate. Dr Pring indicated that the Indicators were developed by RANZCP in 1998 and practices had changed. Ms Munro agreed to forward the minutes of the last Clinical Indicator Review Committee meeting to Dr Lammersma, so that this issue could be pursued through RANZCP.

The meeting agreed that the ACHS Clinical Indicators should be reviewed.

RESOLVED (UNAMIOUSLY)

That the Strategic Planning Group for Private Psychiatric Services requests Ms Moira Munro to liaise with Royal Australian and New Zealand College of Psychiatrist (RANZCP) representatives, Dr Lammersma and Mr Harry Lovelock concerning the review process of clinical indicators for mental health developed by the RANZCP and Australian Council on Healthcare Standards in 1998.

4.3 PSYCHIATRISTS REPORT

The Chair then invited the RANZCP and AMA representatives to report on any current issues relevant to psychiatrists, which require consideration or action by the SPGPPS.

4.3.1 Mother and Baby Admissions

Dr Jo Lammersma reported on the issue of a mother admitted for psychiatric treatment, and some Health Funds refusing to pay benefits for the baby. This led to the RANZCP establishing a working group on post–natal psychiatry involving Consumers and Carers, Health Funds, and Hospitals. The working group developed guidelines that were considered by the February 2005 meeting of the RANZCP General Council. Council, however, requested changes to the wording to make it relevant to both Australia and New Zealand. Dr Lammersma anticipated that the guidelines would be revised and re–presented to the August 2005 meeting of the RANZCP General Council. Once approved, the guidelines will be a public document. Dr Lammersma reported that a copy of the document would be circulated to the SPGPPS Secretariat for distribution, when available.

4.3.2 New Medicare Benefits Schedule (MBS) Item

Dr Lammersma reported that the new consultation MBS Item for psychiatry had been approved and became available in May 2005. A three–month pilot of the new Item was conducted in South Australia, which finishes on 30 June 2005. Dr Lammersma had been involved with that pilot and felt that the new Item was working well. There was also a familiarization package co–ordinated by RANZCP, which was trialed in both South Australia and Western Australia. The South Australian Government has continued the funding to extend the pilot through the Australian Divisions of General Practice for the remainder of 2005.

4.3.3 State–based Referral Directories

Dr Lammersma reported that the new state–based referral directories are now available on the RACGP website. The Directories provide GPs with access to information about the various psychiatric sub–specialities, and where their practitioners can be found. RANZCP is also looking at a way to give psychiatrists access to the Directory.

4.3.3 Clinical Practice Guidelines

Dr Lammersma reported that RANZCP is producing another set of Clinical Practice Guidelines for consumers and carers, funded by the Australian Government. This publication will be A5 size and also available on the RANZCP website.

4.3.4 RANZCP Submissions

Dr Lammersma reported that RANZCP has also been involved in preparing submissions to the many enquiries currently being conducted into aspects of mental health service provision. RANZCP will be presenting to the Senate Select Committee into Mental Health in Melbourne in early July 2005. The Australian Government's Report on the Inquiry into the Detention of Cornelia Rau (Palmer Inquiry) will be released soon. As a result of that Inquiry, RANZCP has been invited to participate in the revision of the Immigration Act.

4.3.5. Training

Dr Lammersma reported that the Fellowship Board of the College is looking at the issues surrounding the training of psychiatrists in private practice**.** Mr Lovelock reported that the Australian Government is funding the College to develop an on–line orientation package for overseas trained doctors and specialists and also a rapid assessment pilot project to try to improve candidates' pass rates. At the moment, overseas–trained psychiatrists wanting to become Fellows of the College have a pass rate of 20%, compared to Australian registrars of 67%.

Dr Lammersma reported that over the next two months RANZCP will be involved in accreditation by the Australian Medical Council.

4.3.6 AMA Submissions

Dr Nothling reported that he and Dr Bill Pring recently appeared before the Senate Select Committee into Mental Health, for the AMA. Dr Nothling reported that the Committee's focus of questioning was on:

- the effect of detention on mental health, the outcomes of de–institutionalisation for the patient population; and
- the current view of prisons as defacto mental institutions and the adequacy of their mental health services.

The Committee also expressed interest in the difficulties of access to psychiatrists and how the system could be improved. That led to a discussion of workforce issues and how the the profession could be made more attractive. The Committee had received considerable feedback from carers and were interested in the AMA's views on relaxing the privacy provisions.

Dr Nothling reported to the SPGPPS that the Federal AMA has strong interest in mental health and this has been reflected in the AMA budget submission to the Federal Government and the AMA submission to the House of Representatives Standing Committee on Health Financing. The new Vice President of the AMA is a psychiatrist, Dr Choong–Siew Yong.

4.4 GENERAL PRACTITIONER REPORT

Dr Kable reported that the Royal Australian College of General Practitioners (RACGP) has appointed a full time project officer for mental health issues.

4.4.1 Better Outcomes in Mental Health Care (BOiMHC) Program

BOiMHC Program aims to improve the quality of and community access to primary mental health services by supporting general practitioners (GPs) in their role of providing services to people with a mental health problem.

The Program is comprised for the following components.

1. Education and training for GPs
2. A 3 Step Mental Health Process
3. MBS Items for GP Focussed Psychological Strategies
4. Access to Allied Psychological Services
5. Access to psychiatrist support

Dr Kable reported that BOiMHC has been re–funded under the current budget. It is unclear as to how the detail of this will emerge. There has been great difficulty in getting any detail from the Australian Government on this matter.

The General Practice Mental Health Standards Collaboration (GPMHSC) has been invited to apply for ongoing funding to continue its work in setting and implementing standards for training programs for GPs to undertake in health training at Level 1 and Level 2. This application of ongoing funding has been submitted and a verbal indication has been given that this will be approved. The work of the GPMHSC will now be more on a consolidation and outreach approach. We will be seeking to ensure that consumers of mental health care are made better aware of the opportunity to approach their GP with confidence that their mental health problems can be appropriately handled. The distribution of GPs with mental health training is quite wide and there is at least a one in four chance of a practice having an appropriately trained GP on staff. Currently there are 4,287 GPs registered for Level 1 training and 846 registered for Level 2. The uptake of the MBS Item is lagging behind the uptake of the training, which is to be expected.

4.4.2 New Chronic Disease Management (CDM) MBS Items

Dr Kable reported that the major concern for the GPMHSC and its constituent members, is the introduction from 1 July 2005 of new Chronic Disease Management (CDM) Items into the MBS. The new items are intended to make it easier for GPs to manage the health care of patients with chronic medical conditions, including patients who need multidisciplinary care. The CDM MBS Items will apply to treatment of people with asthma, cancer, arthritis, diabetes, heart disease, ***mental illness*** and other chronic conditions. Dr Kable indictaed that the Government has included mental illness in this portfolio of chronic disease, against the advice of all constituent parties, and its own Implementation Advisory Group. The concern is that GPs can now get an incentive payment by preparing a chronic disease management plan for a patient with mental illness regardless of their level of training or experience. It also does not recognise that problems may not be chronic. Many presentations to GPs are of acute mental illness, which need expert management. The whole fabric upon which the BOiMHC initiative was based was that it would improve training levels of GPs who had become a vital part in primary mental health care. This would create the circumstances in which the better outcomes for patients could be expected. The current move where a GP without any additional training or upskilling can get almost the same financial incentive without any training or experience means that the whole system of our standards for Level 1 and Level 2 training may be under threat. At present, the only access to the allied health components of the BOiMHC initiative is via registration through Level 1 training. GPs with Level 1 training can decide to refer their patient for 6, or sometimes 12, sessions with a psychologist engaged by the Division of General Practice for that purpose. The sessions can be at a little or no cost to the patient. Under the new CDM MBS Items there will be some access through the Items to five allied health visits. These are however on a rebate basis and cover all allied health services for a patient for the year.

Dr Kable reported that the GPMHSC met on 20/21 June 2005 to consider the implications of this situation. Unfortunately, no representative from the Australian Government was available to participate in discussion of this matter. The Government has indicated it will not be in a position to discuss this matter until September 2005. GPMHSC resolved to write to the Australian Government expressing their concern about the developments and the inability of the Government to make officers available to explain the new CDM MBS Items and where they saw the GPMHSC and its work progressing.

Dr Lammersma indicated that the RANZCP would be concerned if the introduction of the CDM MBS Items led to a reduction of mental health training among GPs. Secondly, much of the work that GPs have been doing is not among the chronically ill psychiatric population, but more in the management of acute mental illness. The third concern is the loss to the patient of much of their potential access to allied health care, which was much broader and more generous under the BOiMHC initiative. Dr Lammersma indicated that the cap on services put in place by the Australian Government to contain costs acts as a disincentive to uptake of the BOiMHC Program.

Ms Saw reported that the Australian Government has committed $228.5 million over four years to 2008–2009 for best practice management of patients with mental health problems. This funding is available for the following.

- $102 million to continue the BOiMHC Program.
- $40.5 million for the expansion of BOiMHC Program.
- $86 million to fund new CDM MBS Items.

Ms Saw indicated that all components of BOiMHC Program remain available to practitioners. The $86 million funding that was originally to be allocated specifically for allied health through BOiMHC has now been put into the CDM MBS Items and there is no way to reverse this funding decision at this time.

Dr Pring indicated that this change might be an opportunity to adequately address people's mental health needs as well as their chronic disease management needs, that is, to encourage a holistic approach.

4.5 HEALTH FUND REPORT

4.5.1 Medical Reports to Health Funds

The Chair reported that at the 39th SPGPPS Meeting, the SPGPPS requested its Health Fund Representative, Mr Brian Osborne, to follow–up the correspondence received by the RANZCP, in June 2004, which raised concerns over the level of detail required in medical reports to Health Funds to obtain extensions of funding for Day Programs. Following that meeting the SPGPPS Secretariat provided a copy of the original correspondence received by the RANZCP for Mr Osborne.

In subsequent discussions between Mr Osborne and the RANZCP Consumer Relations and Complaints Officer, Mr Allen White, it was agreed that Mr White would follow–up this matter by making direct contact with the psychiatrist involved. Mr White reported to Mr Osborne on 12th May 2005 that despite writing and leaving a telephone message, he had not yet heard back from the psychiatrist. Mr White subsequently forwarded to Mr Osborne correspondence received from the psychiatrist on 19 May 2005.

The correspondence mentions the health fund involved. Unfortunately, it does not include the original request from the health fund, but contains the statement from the fund that:

> *Should further days be required we would request pre–approval including details of progress, days required and expected outcome of treatment plans.*

A review of this episode indicates that there was no written request by the health fund to the psychiatrist for any further information.

The health fund believes a verbal request from its funds claims officer was directed to either the private psychiatric hospital concerned, as had happened on all previous occasions, who then contacted the psychiatrist, or to the psychiatrist directly. Advice was provided by the Health Fund that the letter written on 3 June 2004 by the psychiatrist, taken in conjunction with the request from the hospital for a further 40 days funding did not address those matters noted in the previous health fund approval.

The Health Fund was seeking to understand why this member required a further 40 days treatment when they had already (by 1 June 2004) received inpatient treatment at the private hospital as either an overnight or day patient for 16 of the 21 weeks of calendar year 2004 (86 days in total). In addition, this second request was for a further 40 days over 10 weeks, rather than the 4 weeks requested by the hospital and the psychiatrist one month previously.

There is no evidence to support that the Health Fund concerned had asked for:

> *"highly specific personal and medical details about the patient, their condition and treatment."*

Indeed, the request for further information would appear eminently reasonable.

Mr Osborne requested that in respect of issues that are specific to a Health Fund and a particular Hospital or patient, the matter be addressed through the Health Fund representatives directly rather than through the forum of the SPGPPS as a whole.

4.6 AUSTRALIAN GOVERNMENT REPORT

4.6.1 Guidelines for Determining Benefits for Health Insurance Purposes for Private Patient Hospital–based Mental Health Care

The Chair reported that the 39th SPGPPS Meeting requested its constituent organisations to review the current *Guidelines for Determining Benefits for Health Insurance Purposes for Private Patient Hospital–based Mental Health Care* and advise this meeting as to whether the Guidelines require review in 2005.

Ms van der Wal reported that the SPGPPS Secretariat has received the following responses

DoHA	No changes proposed, but will be advised by others
APHA	No changes required
RACGP	No changes required
RANZCP	No changes required
Consumers	No changes required
AMA	To be advised
AHIA	To be advised
Carers	To be advised
DVA	To be advised

Ms Judy Hardy reported that Health Funds considered that the focus should be on the implementation of the Guidelines rather than amending them.

After discussion, it was agreed that the Guidelines were not in need of amendment, though an appendix may need to be drafted as discussed under **Agenda Item 3.3** above.

4.6.2 Review of the National Standards for Mental Health Services

The Chair reported that the Australian Government is currently drafting a statement of requirements for an open tender process for the Review of National Standards for Mental Health Services.

Stakeholders across the sector have for some years articulated a need for review of the National Standards both as a means of ensuring their ongoing relevance, currency and compatibility with other quality assurance processes.

Stakeholder commitment to the National Standards and the call for review were reflected strongly in the Evaluation of the Second National Mental Health Plan. The *National Mental Health Plan 2003–2008* further reflects this commitment. Key Direction 27.4 of the Safety and Quality theme is to 'Review national standards to ensure their relevance for key groups with particular needs'. Consultation with the private sector is considered an integral part of this review.

Ms Saw reported that the Review had yet to go out to public tender, but it is anticipated that it will shortly.

4.6.3 National Mental Health Information Priorities 2nd Edition

The *National Mental Health Information Priorities 2nd Edition* was developed through the AHMAC National Mental Health Working Group's Information Strategy Committee (ISC) to guide the development of national mental health information to 2008 and beyond. This document has been endorsed out of session. This will be available as of July 2005.

4.6.4 Key Performance Indicators for Australian Public Mental Health Services

The document titled *Key Performance Indicators for Australian Public Mental Health Services* has also been endorsed and is currently being printed.

4.6.5 National Survey of Mental Health and Well–being for Australia

Ms Saw reported that a workshop had been held to scope out a second National Survey of Mental Health and Well–being for Australia. There is an adult general survey in the ABS work program for September to December 2007. There is some work around the content of the survey, comparability and disability issues arising out of the workshop. Ms Saw indicated that the survey should not just repeat the last survey

Some of the issues that were being considered were if and how this survey might cover the mental health of Indigenou! s peoples, children and adolescents, and older persons – all of which are of interest to the Australian Government. Ms Saw reported that there were 150 peer–reviewed articles coming from the last survey, only one of which was on older people.

Ms Saw reported that Mr Nathan Smyth has been appointed as the permanent Assistant Secretary for the Health Priorities and Suicide Prevention Branch.

4.6.6 Department of Veterans' Affairs Report

Mr Maurie O'Connor reported that the DVA *Clinical Practice Guidelines for Alcohol Treatment (*DVA Guidelines) had been produced and copies were distributed at the meeting. Mr O'Connor indicated that he would be willing to give a brief presentation on the Guidelines at the next meeting of the SPGPPS to explain what they are and how they are being used. Mr O'Connor explained that the DVA Guidelines differed from the National Drug and Alcohol Research Centre *Guidelines for the Treatment of Alcohol Problems* (NDARC Guidelines) in that the DVA Guidelines are industry guidelines developed to inform the planning and purchasing of alcohol–related services. The DVA

Guidelines comprise general recommendations and sections on screening and assessment, problem drinking, withdrawal, relapse prevention and alcohol and Post Traumatic Stress Disorder (PTSD).

Mr O'Connor reported that DVA has had a submission approved by the Repatriation Commission for a series of initiatives concerning mental health. One initiative is a new look at purchasing and planning, which will involve a move to more community oriented services, thereby broadening the base of mental health services in DVA. Most current services are tertiary. DVA aims to build up the self–care, primary and secondary range of services and interventions. The Government has recently set up the National Veteran's Health and Well–being Forum as a consultant body.

Mr O'Connor reported that DVA is about to bring online the DVA Data Mark, which will enable DVA to look at a range of data from a number of sources concerning the services being used within DVA. This can also be used as a research tool.

5. OTHER BUSINESS

5.1 PRODUCTIVITY COMMISSION HEALTH WORKFORCE STUDY

The Chair reported that the Australian Government Productivity Commission has been requested to undertake a research study to examine issues impacting on the health workforce including the supply of, and demand for, health workforce professionals, and propose solutions to ensure the continued delivery of quality health care over the next 10 years.

The SPGPPS noted a copy of the Issues Paper titled, *The Health Workforce* the Productivity Commission released in May 2005. SPGPPS representatives were requested to carefully review this fully self–explanatory Paper and its Appendices in preparation for discussion at this meeting and determine whether the SPGPPS wishes to make a submission to the Productivity Commission by 31 July 2005.

The Chair indicated that any projected increases in the desperately needed health workforce will take anywhere from 5 to 10 years to have an impact. The Chair invited Mr Harry Lovelock to address the meeting on the views of the RANZCP, which has a committee looking at this issue.

Mr Lovelock reported that the College intends to put forward a submission to the Productivity Commission. There are some issues that need responding to around the use of national competition policy and market friendly mechanisms. It is not at all certain what the consequences may be of opening up health workforce training to some sorts of competitive tendering arrangements, or market testing arrangements. Mr Lovelock indicated that the Review of National Competition Policy was highly relevant to this issue and was available for viewing on the website at: ***http://www.pc.gov.au/inquiry/ncp/finalreport/ncp.pdf***. The Australian Competition and Consumer Commission (ACCC) is also reviewing all the medical colleges. Mr Lovelock welcomed any input the SPGPPS might wish to make to the RANZCP submission.

The Chair indicated that, in relation to the tendering of various services including training, the implementation of such a scheme would be problematic unless the tender meets the standards requirements of the various Colleges. Generic training or less training to meet demand was also not a realistic option and would lessen the quality of the service in the long–term. Dr Brian Kable reported that general practice had served as the role model for tendering training. For 25 years RACGP organised the training program for aspiring GPs, set the curriculum standards, and conducted the examinations. This was seen as anti–competitive and the program was dismantled. There are now 20 regional training

programs for GPs, operating on a tendering process, costing in excess of $75 million dollars a year compared to $25 million a year when run as a single program under the aegis of RACGP. The Government also decreed that half the training take place in rural settings, which became a major disincentive to capable registrars contemplating careers in general practice, judging by recent failure rates of 70%. The GP workforce is comprised of 60% women and 50% of all GPs work part–time. There is a need to factor into the numbers the concept of full–time equivalents, given the nature of the current medical workforce together with the overall reluctance of recent graduates to work very long hours.

Dr Nothling indicated that the AMA, as representative of a diverse group, would be making a submission on the Productivity Commission Study with a broad perspective. There are very few organisations capable conducting the level of training currently implemented by the specialist Medical Colleges. Changing who does the training will likely have little impact on the numbers in the health workforce. The danger lies in lowering the standards to increase numbers. The other danger lies in a piecemeal approach. Solving the problem of GP shortages by recruitment from another health sector does nothing to deal with the overall shortage of medical personnel. An integrated systemic approach is required. There would have to be accommodations made for some specialties, which are no longer trained in the public sector. That has ramifications for providing those services in the public sector.

The Chair reported that the State/Federal input on training is an issue. Training is done in State hospitals with the positions funded by State Government. The Federal Government determines what sorts of requirements there will be. The Chair reported that the Medical Training and Education Council (MTEC) committee in NSW, is looking at medical specialty training in every speciality and is currently preparing a report for the NSW Government. Their proposal involves a multi–tiered oversight by many committees, which leaves less resources for the actual training. The AMC Committee is keen to get psychiatrists trained in the private sector. MTEC is proposing a pilot study to begin in 2007.

Dr Nothling advised that the AMA National Conference reported that the United States of America will have a huge surplus requirement for doctors over the next 20 years thereby competing for other country's medical graduates. This international trend is exacerbated by countries not having worked out what their medical personnel requirements are. The losers are likely to be developing countries unable to retain their trained workforce against the more attractive offers coming from the developed world.

Dr Kable reported that the BOiMHC initiative was premised on not being able to maintain a sufficient number of psychiatrists and enabling GPs to step in and reduce some of the demand.

Ms Munro indicated that Hospitals supported the funding of training of the mental health workforce in the private sector. This is happening in some Hospitals but only funded by Medicare. Dr Lammersma reported that RANZCP is looking at this issue and that there are precedents for funding of training positions outside of the public system. Ms Suzie Saw reported that it would be useful for the newly forming AHMAC NMHWG Workforce Advisory Group to have the input of the varied perspectives of SPGPPS stakeholders on what could be tackled regarding workforce, with particular reference to innovation, retention, supply and workforce attraction etc. Dr Lammersma commented that seeking funding to enabling registrars to train in the private sector is seen as one strategy for increasing the numbers of people seeking to train as psychiatrists. RANZCP has a major problem filling their training positions.

The Chair reported that SPGPPS stakeholders will be making their separate submissions to the Productivity Commission Health Workforce Study. The meeting agreed to put in a general submission as a supportive measure to the other non–Government stakeholder submissions. SPGPPS Members and Observers agreed to forward any comments they might wish to have included in the SPGPPS submission to the Secretariat.

The meeting agreed that the Secretariat would circulate a draft of the general SPGPPS submission to Members and Observers around the end of the first week in July.

RESOLVED (UNAMIOUSLY)

That the Strategic Planning Group for Private Psychiatric Services requests the Secretariat to prepare a Submission to the Productivity Commission Health Workforce Study.

5.2 STATEMENT FROM MEETING OF AMA, APHA, CHA AND AHIA REPRESENTATIVES

The Chair reported that on Thursday, 17 March 2005 representatives from the AMA, APHA, CHA, and AHIA met to consider ways of improving the value of private health in Australia. The Minister for Health and Ageing, the Hon. Mr Tony Abbott MP addressed that meeting and encouraged the group to come forward with recommendations to improve private health. The SPGPPS noted a copy of the statement from the 17 March meeting, which is set out below.

Statement from meeting of AMA, APHA, CHA and AHIA representatives

17 March 2005

1. Doctor, hospital and health insurance representatives met informally today to consider ways to improve the value of private health in Australia. The Minister for Health and Ageing, Mr Tony Abbott addressed the meeting and encouraged the group to come forward with recommendations to improve private health.
2. The meeting agreed to examine ways to improve patient services in the areas of psychiatric care, palliative care, appropriate use of office based surgery, out of hospital nursing and admission and discharge arrangements. The improvements could involve amendments to the National Health Act and the Health Insurance Act. It also includes the provision of step down, rehabilitation, transitional and alternative care options.
3. The parties strongly support the early implementation of shared electronic systems for claiming and payment for all private inpatient medical services without exception. Such electronic systems will support high quality informed financial consent which helps patients and improve the value of private health insurance and may involve minor legislative change.
4. The parties agreed to look at ways to expand Emergency Services in private hospitals and make recommendations to the Minister as necessary.
5. The parties agreed to improve the way informed financial consent is achieved.
6. The parties agreed to meet again soon after further joint work has been carried out to develop these broad ideas more.

Mr Taylor reported that following the March meeting, there had been further discussions between AMA, AHIA, APHA and CHA (the Promoting Private Health Group (PPHG)) to progress these issues. Of particular interest to the SPGPPS, is how possible extension of private health cover might lead to improved access to psychiatric care. The PPHG recognised that it lacked the necessary expertise to develop proposals in this area and accordingly the AMA, on behalf of the PPHG is seeking the views of the SPGPPS on this matter.

The Chair invited Dr Nothling to speak to this item. Dr Nothling indicated he had suggested that this matter be referred to the SPGPPS for comment. Dr Pring pointed out that the SPGPPS IMWG has been addressing the issues and has been making progress. It was acknowledged that the meetings of PPHG are about the very broad issues surrounding private health services, not just mental health. Ms Saw clarified that there are a number of issues in mental health that emerge time and again without adequate resolution such as step–downs and rehabilitation provision. The nature of the mental health reform agenda is much more complex than other areas. Nevertheless, there is the issue of having two fora looking at the provision of mental health (as a part of private health). Mr Callanan indicated that most of the items referred to in the document are currently on the Government's private health agenda. One of the major changes under discussion canvassed before the election was enabling health funds to use Hospital Tables to fund substitutes for in–patient care. This change would require major legislative change and it was noted that the timeframe for the PPHG's deliberations appears to be the end of the year.

Mr Osborne suggested that the PPHG appeared to be looking at legislative or rule or fund changes that could be quickly implemented to open things up. Mr Osborne indicated that Health Funds are keen to have legislative change, which will facilitate change across the board, from mental health to other areas. Mr Abbott is supportive of this strategy. Mr Osborne indicated that when he had clarified the current situation with AHIA, he would be in a better position to address the issues PPHG has under discussion.

Mr Taylor reported that the next meeting of the PPHG would be held at AMA House in Canberra on 4 July 2005. It is likely that Mr Osborne, Dr Pring and Ms Turnbull will be invited to participate. The SPGPPS agreed that Mr Taylor and Dr Pring would collaborate on a briefing paper for the mental health representatives participating in the 4 July 2005 PPHG meeting on the position that the IMWG had reached in its deliberations.

RESOLVED

That the Strategic Planning Group For Private Psychiatric Services requests Mr Phillip Taylor and Dr Bill Pring to prepare a briefing document for psychiatrist representatives participating in the PPHG Meeting scheduled for 4 July 2005.

6. NEXT MEETING

The next meeting of the SPGPPS will be held on **Friday, 7 October 2005** at RANZCP headquarters, 309 La Trobe Street, Melbourne. The meeting will commence at 9:30 AM and conclude at 4:00 PM.

The *SPGPPS Dinner* will be held on **Thursday, 6 October** from 7:00 PM at a venue to be advised.

7 CLOSE

There being no further business, the Meeting closed at 4:00 PM.

Dr Yvonne White	Mr Phillip Taylor	Ms Bronwen van der Wal
SPGPPS Chair	SPGPPS Executive Officer	SPGPPS Administrative Officer