STRATEGIC PLANNING GROUP FOR

SPGPPS

PRIVATE PSYCHIATRIC SERVICES

REPORT OF THE
THIRTY NINTH
(39TH)
MEETING

HELD AT
ADELAIDE HITLON HOTEL
233 VICTORIA PARADE
SOUTH AUSTRALIA

ON
FRIDAY, 18 MARCH 2005

REPORT OF MEETING

Glossary of Acronyms and Terms used repeatedly in this Report

AHMAC	Australian Health Ministers Advisory Council
APHA	Australian Private Hospitals Association
AMA	Australian Medical Association
BOIMHC	Better Outcomes In Mental Health Care Initiative
CDMS	SPGPPS Centralised Data Management Service
DoHA	Australian Government Department of Health and Ageing
GP(s)	General Practitioner(s)
HCP	Hospital Casemix Protocol
Health Fund(s)	Private Health Insurance Fund(s) that pay benefits for psychiatric care
Hospital(s)	Private Hospital(s) with psychiatric beds
IMWG	SPGPPS Innovative Models Working Group
ISC	AHMAC NMHWG Information Strategy Committee
ISWG	SPGPPS Information Strategy Working Group
NMHWG	AHMAC National Mental Health Working Group
RACGP	The Royal Australian College of General Practitioners
RANZCP	The Royal Australian and New Zealand College of Psychiatrists
SPGPPS	Strategic Planning Group for Private Psychiatric Services

The Thirty–Ninth (39th) SPGPPS Meeting (or the Meeting) was held on Friday, 18 March 2005 at Adelaide Hilton Hotel, in Adelaide South Australia.

1. PROCEDURAL MATTERS

1.1 OPENING AND WELCOME

Dr Yvonne White opened the meeting at 9:00 AM. 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

Carer Representative

8. Ms Ruth Carson

Australian Government

9	Ms Suzy Saw	Health Priorities and Suicide Prevention Branch
10	Mr Peter Callanan	Private Health Insurance Branch
11	Ms Katherine Bates	Private Health Insurance Branch

Private hospitals with psychiatric beds (Hospitals)

12.	Ms Paul Mackey	Proxy for Ms Moira Munro
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.	Mr David Morton	Department of Veterans' Affairs (DVA), Chair SPGPPS SDWG
2.	Ms Moira Munro	Hospital Representative and SPGPPS Deputy Chair
3.	Ms Sharon Brownie	RANZCP Observer
4.	Dr Jonathan Phillips	Chair SPGPPS Forum

1.2. REPORT OF THE 38TH SPGPPS MEETING

The Meeting approved the draft report of the 38th SPGPPS Meeting held on 26 November 2004 in Canberra, Australian Capital Territory following minor amendment.

RESOLVED (UNANIMOUSLY)

That the Strategic Planning Group For Private Psychiatric Services (SPGPPS) approves the Report of the 38th SPGPPS Meeting, held on 26 November 2004 in Canberra, 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 37TH SPGPPS MEETING

The SPGPPS noted and updated the following Progress Report on Actions Arising from the 38th SPGPPS Meeting. Mr Phillip Taylor reported there were no out–of–session decisions.

	Agenda Items	ACTION OFFICER (S)	STATUS
	Report on the 38th SPGPPS Meeting		
➢	Draft and circulate report of 38th Meeting for comment	Secretariat	Done
➢	Revise Report based on comments received and prepare final	Secretariat	Done
➢	Agenda Item 39th SPGPPS Meeting	Secretariat	Done
2	Report on the 37th SPGPPS Meeting		
➢	Post Report on the SPGPPS website	Secretariat	Done
2.1	SPGPPS Finance Committee (FC)		
➢	FC to advise 39th SPGPPS Meeting on budget position after its March 2005 Meeting.	Dr Nothling	*Pending*
➢	Agenda Item 39th SPGPPS Meeting	Secretariat	Done
2.2	SPGPPS Meeting Dates 2005		
➢	Organise venues etc for all SPGPPS Meetings for 2005	Secretariat	Done
➢	Organise for ISWG to meet back–to–back with SPGPPS	Secretariat	Done
➢	Circulate meeting dates in the Draft Report	Secretariat	Done
3.1	Innovative Models Working Group (IMWG) Report		
➢	Refer Stakeholder Perspectives on Innovative Models to IMWG 7 February 2005 Mtg	Secretariat	Done
➢	Organise IMWG face–to–face Meeting in Canberra @ AMA House 7 February 2005	Secretariat	Done
➢	Agenda Item 39th SPGPPS Meeting	Secretariat	Done
3.2	Information Strategy Working Group (ISWG) Report		
➢	Arrange for SPGPPS website domain change to spgpps.com.au	Secretariat	Done
➢	Agenda Item 39th SPGPPS Meeting	Secretariat	Done
3.3	Substance Abuse and Dependency Working Group		
➢	Invite Professor John Saunders to 40th SPGPPS Meeting in Brisbane	Secretariat	Done
➢	Agenda Item 39th SPGPPS Meeting	Secretariat	Done
4.1	SPGPPS Logo		
➢	Prepare final version of the SPGPPS logo for letterhead	Secretariat/Graphic Designer	Done
➢	Print new stationary	Secretariat	Done
4.2	Access to Psychiatric Beds		
➢	Ascertain rates of involuntary detention in the private sector	Secretariat	Done
➢	Agenda Item 39th SPGPPS Meeting	Secretariat	Done
4.3	Privacy Act Review		
➢	Prepare MHPC Submission on Privacy Act Review for OFPC	Dr Pring/MHPC/Secretariat	Done
5.1	AHMAC NMHWG Report		
➢	Write to the RANZCP on the importance of outcome measurement in private practice	Dr White/Secretariat	Done
5.4	Psychiatrist's Report		
➢	Health Funds basis for Medical Report Requests deferred to 39th SPGPPS Meeting	Mr Brian Osborne	*Pending*
➢	Consumer/carer/health Fund/Hospital Reps Inclusion on RANZCP post–natal WG	Dr Jo Lammersma	Done
➢	Follow–up with Funds limiting ECT deferred to 39th SPGPPS Meeting	Mr Brian Osborne	*Pending*
➢	Agenda Item 39th SPGPPS Meeting	Secretariat	Done
6	Next Meeting		
➢	Organise 39th SPGPPS Meeting Hilton Adelaide Hotel	Secretariat	Done
➢	Organise 6th SPGPPS ISWG Meeting Adelaide Hilton Hotel	Secretariat	Done
➢	Organise SPGPPS Dinner	Secretariat	Done

2. FINANCIAL AND OPERATIONAL MATTERS

2.1 SPGPPS FINANCE COMMITTEE REPORT

The Chair invited Dr Martin Nothling, Chair SPGPPS Finance Committee, to report on the 5th Finance Committee Meeting, held on Wednesday, 2 March 2004 via teleconference.

In opening his address, Dr Nothling tabled a copy of the draft report of that Meeting and reported that it constituted the 4th Quarter 2004 meeting of the Committee. The SPGPPS noted that the AMA was not able to provide a final Statement of Income and Expenditure for 2004 until after the end of the AMA Financial Year on 31 December 2004. Dr Nothling explained that expenditure in December 2004 could not be accurately calculated until February 2005, after all records of expenditure for December 2004 were received, and the AMA Audit of accounts had been completed.

Dr Nothling then advised on the funding position of the SPGPPS, its CDMS and National Network for the AMA Calendar Year of 1 January 2004 to 31 December 2004 in accordance with the *Statement of Income and Expenditure* provided by the AMA.

2.1.1 SPGPPS

Dr Nothling reported that, at the end of 2004, there was a surplus of $8,658 remaining in the SPGPPS Budget for 2004. Following discussion, the SPGPPS supported the Finance Committee's recommendations that this surplus be carried forward into the 2005 SPGPPS income stream.

2.1.2 CDMS

Dr Nothling reported that, at the end of 2004, there was a surplus of $29,740 remaining in the CDMS Budget for 2004. Dr Nothling reminded the SPGPPS that, since late 2003, the SPGPPS Finance Committee, in consultation with the AMA, had been managing an overspend of $24,943 from the Year 2 CDMS budget (June 2002 to May 2003). The overspend was originally associated with significant unforeseen expenditure related to support, consultation, and infrastructure, together with accrued annual leave entitlements for leave not taken by the SPGPPS Information Officer, Mr Allen Morris–Yates, during that period. In accordance with the recommendations of the SPGPPS Finance Committee, this overspend was quarantined by the AMA on 31 December 2003, with the intention of reviewing the problem once Mr Morris–Yates had taken all leave owing to him. Dr Nothling explained that, in 2004, the overspend was greatly reduced through a reduction in expenditure on workshops for Hospitals and Payers, and by Mr Morris–Yates having taken his accumulated annual leave. The combined effect of these savings resulted in a surplus of $29,740 in the CDMS Budget at the end of 2004.

The SPGPPS then supported the Finance Committee's recommendation that the 2004 surplus of $29,740 be used to cover the previously quarantined overspend of $24,943. The SPGPS further agreed that the remaining $4,797 should be carried forward into the income stream for the CDMS in 2005.

2.1.3 NATIONAL NETWORK

Dr Nothling reported a small surplus of $213 remaining from the National Network Budget for 2004. The SPGPPS supported the Finance Committee recommendation that the surplus be carried forward into the 2005 National Network income stream.

The SPGPPS then passed the following resolutions.

RESOLVED EN BLOC (UNANIMOUSLY)

1. *That the Strategic Planning Group For Private Psychiatric Services (SPGPPS) notes the Draft Report of the Fifth SPGPPS Finance Committee Meeting, held on 2 March 2005 via teleconference.*
2. *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 December 2004.*
3. *The SPGPPS notes the surplus of $8,658 remaining in the SPGPPS Budget for 2004 and directs that the Australian Medical Association carry forward this surplus into the SPGPPS Budget for 2005.*
4. *The SPGPPS notes the surplus of $29,740 remaining in the SPGPPS Centralised Data Management Service (CDMS) Budget for 2004 and directs that Australian Medical Association (AMA) use this surplus to cover the previously quarantined CDMS overspend of $24,943. The SPGPPS directs that the AMA carry forward the remaining $4,797 into the CDMS Budget for 2005.*
5. *The SPGPPS notes the surplus of $213 remaining in the National Network for Private Psychiatric Sector Consumers and carers (National Network) Budget for 2004 and directs that the Australian Medical Association carry this surplus forward into the National Network Budget for 2005.*

2.2 SPGPPS CDMS AND NATIONAL NETWORK PROGRESS REPORT 2004

The SPGPPS then considered the draft *SPGPPS, Centralised Data Management Service, National Network for Private Psychiatric Sector Consumers and Carers, Progress Report 2004,* which had been prepared by the SPGPPS Secretariat and circulated prior to this meeting.

The SPGPPS Executive Officer, Mr Phillip Taylor reported that the Progress Report provides a high level of detail on the activities of the SPGPPS, its CDMS and the National Network during 2004. The SPGPPS noted that this is the first progress report, as required under the overarching *AMA Agreement for Services 2004–2006,* which took effect from 1 January 2004.

Mr Taylor reported that the auditors, KPMG, had prepared draft letters of acquittal, for attachment to the Progress Report following completion of their audit of the SPGPPS, CDMS and National Network accounts. The AMA has indicated that these letters will be finalised, following endorsement of the Progress Report by the SPGPPS.

Following minor amendment, the meeting endorsed the Progress Report and commended the Staff of the SPGPPS Secretariat on the quality and comprehensiveness of the Report. The meeting agreed the Report should be forwarded to the signatories to the new AMA Agreement for Services 2004–2006 and posted on the SPGPPS website. Mr Taylor explained that a copy of the Report would also be circulated to the contacts listed on the SPGPPS database.

There was consensus that the Progress Report was a significant achievement and an important source document for promulgating the work of the SPGPPS, CDMS and National Network.

It was agreed that a form of words for a public launch of the Progress Report should be developed that enabled SPGPPS constituent organisations to advertise the existence of the Progress Report through their press releases, newsletters, journals and websites.

RESOLVED EN BLOC (UNAMIUOSLY)

1. *That the Strategic Planning Group for Private Psychiatric Services (SPGPPS) endorses the report titled, The SPGPPS, its Centralised Data Management Service, and the National Network for Private Psychiatric Sector Consumers and Carers – Progress Report 2004, and adopts the statements of income and expenditure presented in Tables 1.6, 2.3 and 3.6 of this Report.*

2. *That the SPGPPS requests that the final version of the report titled, The SPGPPS, its Centralised Data Management Service, and the National Network for Private Psychiatric Sector Consumers and Carers – Progress Report 2004, be forwarded to the signatories to the AMA Agreement for Services 2004–2006.*

3. *That the SPGPPS directs that the report titled, The SPGPPS, its Centralised Data Management Service, and the National Network for Private Psychiatric Sector Consumers and Carers – Progress Report 2004, be made available on the SPGPPS website at: www.spgpps.com.au.*

4. *That the SPGPPS directs that the report titled, The SPGPPS, its Centralised Data Management Service, and the National Network for Private Psychiatric Sector Consumers and Carers – Progress Report 2004, be used as an important source document for promulgating the work of the SPGPPS, its Centralised Data Management Service, and the National Network for Private Psychiatric Sector Consumers and Carers.*

5. *That the SPGPPS thanks the staff of the SPGPPS Secretariat for preparing the report titled, The SPGPPS, its Centralised Data Management Service, and the National Network for Private Psychiatric Sector Consumers and Carers – Progress Report 2004, and commend the Secretariat on the high quality and comprehensive nature of this Report.*

6. *That the SPGPPS, requests that the SPGPPS Secretariat, in consultation with the Federal AMA and RANZCP Public Relations Departments, develop a form of words concerning the report titled, The SPGPPS, its Centralised Data Management Service, and the National Network for Private Psychiatric Sector Consumers and Carers – Progress Report 2004, that enables SPGPPS constituent organisations to promulgate this Report through their, newsletters, journals and websites.*

3. SPGPPS SUB–GROUP REPORTS

3.1 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 face–to–face in Canberra. The Chair of the

IMWG, Mr Phillip Taylor, was asked to speak to the report. In opening his address, Mr Taylor provided the following overview on the work of the IMWG to date.

The SPGPPS originally established the IMWG in 2003 to encourage the uptake of innovative models of service delivery and enhance co–ordination of care between general practitioners, psychiatrists and hospitals. In response, the IMWG developed a set of *General Principles and Recommendations,* which were endorsed on 20 June 2003 by the 32nd Meeting of the SPGPPS. The IMWG progressed these recommendations throughout the remainder of 2003, and in 2004. In July 2004, the IMWG significantly broadened its Terms of Reference to enable the Working Group to focus on the merits, or otherwise, of different models of service delivery and to explore the barriers to their uptake in the private sector, rather than deliver a series of recommendations that would be difficult to enforce. To inform this work in 2004, SPGPPS stakeholders agreed to present their perspectives on innovative models of care to the SPGPPS. At the 36th SPGPPS Meeting held in March 2004, Health Funds provided their perspective on innovations in funding models for services in the private sector. This was followed in September 2004 by presentation of psychiatrist's perspectives, and consumers and their carer's perspectives, at the 37th Meeting of the SPGPPS. Hospitals and the Department of Veteran's Affairs presented their perspectives in November 2004, at the 38th SPGPS Meeting.

Mr Taylor reported that the purpose of the face–to–face IMWG meeting held on 7 February 2005 was to review and analyse stakeholders presentations to determine what, if any, actions the IMWG or SPGPPS and its other working groups, should undertake. The SPGPPS noted that the outcome of that meeting was agreement that the IMWG would prepare a discussion paper for the SPGPPS exploring the advantages and disadvantages inherent in the Prospective Payment Model (PPM) and the problems involved in the implementation of the model in a competitive environment. Mr Taylor reported that the SPGPPS Secretariat subsequently prepared and circulated a draft Template to facilitate IMWG Member input to the PPM Discussion Paper.

Mr Taylor also reported that the IMWG had recommended that the SPGPPS seek to facilitate the formation of informal support networks for General Practitioners and other stakeholders under the auspices of the Australian Divisions of General Practice.

3.1.1 Discussion

Dr Pring indicated that, in relation to the PPM Discussion Paper, the IMWG was looking at the reasoning as to why a different financial model was necessary for psychiatric care. Mr Brian Osborne responded that from the Health Fund perspective, costs are increasing in all areas of health care and innovative funding models are being implemented by Health Funds in response to those costs. Dr Pring indicated that, while there may not be a strong argument for change, it would be useful for IMWG to know how psychiatry is performing in relation to its costs to Health Funds as a rationale for some changes. Mr Osborne welcomed the opportunity to involve clinicians in health financing discussions and indicated that the AHIA Mental Health Committee should be able to provide its Health Fund representative on the IMWG, Mr Bruce Houghton, with some information on the costs of psychiatric care to Health Funds.

Mr Peter Callanan reported that the Australian Government had endorsed PPM for use in psychiatric hospitals in South Australia (SA). Mr Callanan indicated that before the IMWG reached a point where the PPM Discussion Paper was ready for the public arena, it would be wise to involve the Private Health Insurance Administration Council (PHIAC). PHIAC is responsible for the financial viability of Health Funds and in particular the re–insurance arrangements. PHIAC is interested in how the PPM progresses. Mr Callanan explained that the PPM in SA encompasses both admitted and non–admitted patients, whereas the re–insurance arrangements only apply to admitted patients. There is a reporting system that PHIAC is concerned might have some overlaps. PHIAC developed a supplementary form that excludes non–admitted patients for re–insurance

reporting purposes. Mr Callanan indicated that, as the Australian Government representative on both the IMWG and PHIAC, he would ensure PHIAC was informed of the IMWG deliberations concerning the PPM Discussion Paper.

Dr Pring indicated that arising from the IMWG discussions had been the issue of how the PPM will perform in a situation where there are a larger number of Hospitals in a different capital city with a different mix of Health Funds. Mr Callanan indicated that PHIAC had also raised this issue, given that for the PPM in SA there had only been one Hospital owner with a few Health Funds. Mr Osborne acknowledged the amount of liaison and support provided by the Australian Government for the PPM in SA. He felt that the IMWG approach now provided a unique opportunity to see how the PPM (or any other model funding model) might work to achieve better outcomes. The first major step in the IMWG approach takes into account what clinicians believe are the most effective services and what the consumers and their carers want. The PPM could then be costed within the available funding, so that it operates to produce better outcomes at that funding level. The next major step would then be to address any legislation that might restrict the wider uptake of the funding model.

Mr Paul Mackey asked for clarification as to how *available funding* is determined. Mr Osborne and Mrs Hardy explained that Health Funds determine the proportion of funding to be allocated to mental health largely on an historical funding basis, starting from what has been spent in the previous year. Mrs Hardy explained that the funding issue is the same for Health Funds as it is for governments. In other words, while it is relatively easy for funders to determine what percentage of their overall health budget ***is*** spent on mental health, this does not answer the question of what percentage ***should*** be spent on mental health. The tension funders face between these two questions is further intensified by the plethora of interest groups lobbying for increased funding for their particular area of health.

Mr Osborne then asked whether the PPM Discussion Paper intended to explore how the PPM would operate at a facility, if other facilities in that environment are not using that model, or whether the Discussion Paper intended to look at how the PPM would operate over an entire State where there are other facilities, all of which would have to be encompassed within the PPM. Dr Pring felt that both scenarios would have to be considered. Ms Turnbull also responded and indicated that while IMWG had discussions around the PPM as used in SA, it was essentially the following three principles that emerged from the SA experience that IMWG felt should be able to be applied anywhere.

1. Reduce the incentive for providing overnight in–patient care.
2. Provide an incentive for alternative models of care, not only for community and day–care programs, but for services such as telepsychiatry, which are not currently funded and terribly underutilized.
3. Provide training in best–practice alternatives given that many will only be familiar with in–patient care.

Ms Turnbull explained that these principles would be pursued further in the PPM Discussion Paper.

On another note, Dr White as a Health Fund member, indicated that she often wondered what she received in return each time her Health Fund premiums were increased. In responding to this question, the meeting openly and frankly discussed the difficulties involved in financing private health care. The complexities the private health insurance industry faces in determining their products and making decisions about the allocation of scarce funding resources in an environment of escalating health care costs, was largely the focus of the discussion. The meeting noted that the sustainability of health insurance industry was regularly the subject of forums hosted by the APHA, AHIA and several other organisations. It was also noted that

House of Representatives Standing Committee on Health and Ageing recently announced a new parliamentary inquiry into the complex arrangements currently in place for health funding. The Inquiry will look at ensuring a strong private health sector and making health insurance a still more attractive option to those who can afford it.

RESOLVED (UNANIOUMSLY)

1. *That the Strategic Planning Group For Private Psychiatric Services (SPGPPS) notes the draft report of the 11th SPGPPS Innovative Models Working Group (IMWG) Meeting held on 7 February 2005 in Canberra.*
2. *That the SPGPPS requests that its Health Fund Representative, Mr Brian Osborne, liaise with the Australian Health Insurance Association Mental Health Committee and provide the Health Fund representative on the IMWG, Mr Bruce Houghton, with some information on the costs of psychiatric care to Health Funds.*

The SPGPPS noted that the next meeting of the IMWG would be held via teleconference on Tuesday, 12 April 2005.

3.2 SPGPPS INFORMATION STRATEGY WORKING GROUP (ISWG)

The Chair reported that, in 2003, the SPGPPS established the ISWG 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. The meeting noted that ISWG met on 25 November 2004, (the day preceding the 38th SPGPPS meeting) and a copy of the draft report of the 5th ISWG Meeting, which had been circulated with the agenda and papers, was noted.

RESOLVED (UNANIMOUSLY)

That the Strategic Planning Group For Private Psychiatric Services (SPGPPS) notes the draft Report of the Fifth (5th) Meeting of SPGPPS Information Strategy Working Group, held on 25 November 2005 in Canberra.

The Chair of the ISWG, Dr Bill Pring, was then invited to report verbally on the 6th ISWG Meeting, which was held on 17 March 2005. Dr Pring reported that the ISWG had discussed the following four key areas.

3.2.1 Training for Hospitals participating in the SPGPPS' CDMS

In considering the development of a framework for training and implementation support groups at the local level to ensure the sustainability and integrity of the CDMS, the ISWG had looked at several different models, an alternative modular approach to the provision of refresher and advanced training for participating Hospitals. Hospitals have agreed to look at this approach at the next APHA Psychiatric Sub–Committee meeting.

3.2.2 Consumer Perceptions of Care Measure

The ISWG has established a small Consumer Perceptions of Care (CPoC) Project Team to prepare a CPoC Project Brief titled, *National Implementation of a Consumer Perceptions of Care Measure In Private Hospital–Based Psychiatric Services: Analysis of the issues and a plan for the evaluation and possible trial of a suitable measure.*

At the invitation of the ISWG, the National Network Of Private Psychiatric Sector Consumers and Carers (National Network) had undertaken a comprehensive consultation process in each State and the Australian Capital Territory in order to be in a position to advise the ISWG and the SPGPPS on the National Network's views concerning the following.

1. The issues of perceptions of care thought by the National Network to be important in the receipt of services from private hospital–based psychiatric services.
2. The appropriateness of the *NRI/MHSIP Inpatient Consumer Survey* for use in Australian private hospital–based psychiatric services, particularly in relation to the following.
    2.1. The correlation between the issues identified by the *NRI/MHSIP Inpatient Consumer Survey* with the domains identified by the National Network.
    2.2. The appropriateness of the questions contained in the *NRI/MHSIP Inpatient Consumer Survey* within the Australian cultural context, and for private hospital–based psychiatric services.
    2.3. Any changes that may be necessary to the *NRI/MHSIP Inpatient Consumer Survey* for its use in Australian private hospital–based psychiatric services.
3. The relationship between the MH–CoPES Project and the proposed CPoC Project.
4. The proposed trial of the routine collection of data and regular reporting to Hospitals of information regarding consumer perceptions of care. In particular, the questions to be addressed by the trial, the process for the conduct of the trial, the proposed process for the evaluation of the trial, and the funding of the trial.

The SPGPPS noted that Ms McMahon would report on the National Network's deliberations concerning the CPoC Measure under *Agenda Item 3.3 National Network Report*.

Dr Pring reported that the CPoC Project Brief is currently being re–drafted to reflect the possibility of a multi–stage approach involving initially a pilot, rather than a trial in Hospitals willing to participate. Mr Mackey indicated the APHA Psychiatric Sub–committee would consider this revised approach at their next meeting to be held on 5 April 2005.

3.2.3 Risk Management Strategies For CDMS

Dr Pring indicated that those present at the 6th ISWG Meeting had undertaken a site visit of the security arrangements in place at the new home of the SPGPPS Information Officer, Mr Allen Morris–Yates, for the encrypted data zip files provided by Hospitals participating in the CDMS. Mr Morris–Yates explained that a copy of this data was also stored securely off–site from the SPGPPS Secretariat in a safety deposit box at a bank in Canberra. Dr Pring advised the SPGPPS that the ISWG was satisfied with these risk management arrangements for the CDMS data.

3.2.4 Changes to the Hospital Casemix Protocol (HCP)

Dr Pring reported that, at the request of the IMWG, Mr Morris–Yates had attempted, in early 2004, to identify the provision of Outreach care within the data submitted to the CDMS by participating Hospitals. The difficulties involved, particularly in relation to the considerable variation that exists in how Hospitals record "Outreach care", were reported and considered at

the 3rd ISWG Meeting held in June 2003. To address this problem ISWG asked Mr Peter Callanan to liaise with Mr Allen Morris–Yates and undertake the necessary steps to determine whether the option defined below could be made to the HCP under current legislation.

> Treat each "Outreach care" visit as a Sameday admission (ie, Sameday status = 1 in the HCP) with "Days spent at home" = 1. This option requires more data collection by the Hospital but has the very great advantage of enabling the explicit identification and full coding (in terms of date, time, duration, diagnoses and procedures) of each visit.

The SPGPPS noted that, following the 3rd ISWG meeting, Mr Callanan had organised a meeting to discuss this issue between Mr Morris–Yates, Ms Katherine Bates (DoHA Private Health Insurance Branch), Ms Julie Marr (DoHA Acute Care Strategies Branch), Mr Steve Hann (DoHA Acute and Coordinated Care Branch Health Services Division) and Ms Suzy Saw (DoHA Health Priorities and Suicide Prevention Branch). The meeting was cancelled due to the Australian Government *caretaker* mode for the 2004 Federal election.

The 10th IMWG Meeting, held on 10 November 2004, considered this impasse and agreed that, rather than attempting to co–ordinate another DoHA interdepartmental meeting with Mr Morris–Yates, it would be more appropriate to ask Mr Callanan to invite Mr Steve Hann to participate in the 5th ISWG Meeting scheduled for 25 November 2004 in Canberra. Mr Hann attended that meeting and indicated that, so far as he was aware, there were no legislative or regulatory requirements that would prohibit the SPGPPS and the APHA recommending to Hospitals that they treat each "Outreach care" visit as a Same–day admission. Dr Pring subsequently wrote to Mr Callanan requesting formal confirmation that this was the case. Dr Pring reported that, as Mr Callanan was an apology for this 6th ISWG Meeting, the ISWG had agreed that this matter should be raised with the SPGPPS today for resolution, as Mr Callanan was present.

Mr Callanan responded, apologized for the delay in response, and indicated that he had now had an opportunity to discuss this matter with Mr Hann. Mr Callanan explained that the difficulty lies with calling visits that occur during Outreach care "Same–day admissions". Under current legislation, a Same–day patient is defined as someone who is admitted and discharged on *one* day. With an Outreach program, however, a person is discharged to a facility outside the Hospital (usually their home), for a period of *three* days. When a clinician then visits that patient, for example on day two, the visit triggers a benefit, which has to be paid by a private health insurance fund, or by Medicare if it is a medical practitioner. Technically the visit cannot be called a Same–day admission because the patient is still an admitted patient of the Hospital concerned, until the Outreach program ceases.

A discussion followed, and Mr Morris–Yates and Ms Suzy Saw indicated that the current protocol for recording episodes of care for patients admitted under an approved Outreach program is inconsistent with the protocols guiding the collection of National Minimum Data Sets that Jurisdictions have agreed to report under both current and previous Australian Health Care Agreements, particularly the National Minimum Data Set for Community Based Mental Health Care. The recommended protocol is also inconsistent with the very detailed data collection protocols specified under the agreed National Outcomes and Casemix Collection currently being implemented by public sector mental health services in all Jurisdictions. The current protocol does not enable the volume, intensity or frequency of care provided during the Outreach care component of the admission to be determined. Mr Callanan agreed that was the case and the SPGPPS focused on what could be done to enable these visits to be captured by the HCP.

In determining a way forward, Mr Morris Yates explained that the HCP contains the following Data Item titled, *Same–day status*.

> Sameday status
> Definition: As specified by the following domain.
> Domain: 0 Patient with a valid arrangement allowing overnight stay for procedure normally performed on a same–day basis
> 1 Same–day patient
> 2 Overnight patient (other than type 0 above).

It was suggested that the Domain of this Data Item be expanded to include an additional type of episode of care described as *Occasion of outreach service*, with the code value of *3*. Each visit to the patient that would attract the payment of a benefit under an approved Outreach program would be recorded under the HCP as an instance of this type of episode of admitted patient care. Mr Mackey suggested that this change could be progressed as part of the current review of the HCP, by a resolution from the SPGPPS. Mr Callanan indicated that he would be happy to take a recommendation from the SPGPPS forward. Mr Morris–Yates agreed to prepare a proposal detailing the changes that would be necessary in current Hospital data collection arrangements to resolve the problem with the identification Outreach care in the HCP.

RESOLVED (UNANIMOUSLY)

That the SPGPPS requests that the Australian Government Department of Health and Ageing (DoHA) undertake, as part of the review of the Hospital Casemix Protocol (HCP), the necessary steps to amend the HCP to resolve the problem with the identification Outreach care. The SPGPPS Information Officer is asked to prepare a proposal detailing the changes that would be necessary to resolve this problem, for consideration by the DoHA.

3.3 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.

3.3.1 Consumer Perceptions of Care Measure

Ms McMahon reported that a large part of the 10th Meeting had been devoted to the issues around the use of a Consumer Perceptions of Care (CPoC) Measure in the private sector particularly in relation to the issues identified in the ISWG Report under Item 3.2.2 above. Ms McMahon then explained the process undertaken at the 10th Meeting and it was noted that this had included the following

(a) Workshop on Consumer Perceptions of Care Measures

Ms McMahon explained that the workshop approach was used to determine the following issues relating to consumers perceptions of care, that were thought by National Network members to be important in the receipt of services from private hospital–based psychiatric services.

1. Access
2. Costs
3. Satisfaction with treating psychiatrists
4. Staffing
5. Quality of treatment and variability of therapeutic models
6. Complaints handling

7. Discharge planning
8. Delay with access to psychiatrists and allied health professionals
9. Admission process
10. Involvement of carers
11. Communication with patients
12. Identification of co–morbidities and side effects
13. Issues for younger adults
14. Safety

The Workshop then considered the correlation between these issues and the domains (factors) addressed by the *NRI/MHSIP Inpatient Consumer Survey* (NRI/MHSIP) and determined that the NRI/MHSIP successfully addressed most of these areas. The only areas the National Network felt were not addressed by NRI/MHSIP were *costs* related to private health insurance funds, *satisfaction with treating psychiatrists* and *admission processes*. Ms McMahon indicated that the National Network felt some minor re–wording would enable the NRI/MHSIP to address these issues.

The Workshop also considered the appropriateness of the questions contained in the NRI/MHSIP within the Australia cultural context, and for private hospital–based psychiatric services and some very minor changes were suggested.

(b) Consultation/Reporting Process for the NRI/MHSIP

Ms McMahon reported that the National Network had then considered the proposed local State and Australian Capital Territory consultation and reporting processes for the NRI/MHSIP, as detailed in the CPoC Project Brief, and determined if any amendments were necessary to the proposed consultation and reporting processes. A template for reporting the results of the second stage of initial consultation was also developed.

Ms McMahon reported that following the 10th National Network Meeting, State and Territory Co–ordinators had conducted their consumer and carer consultations in each Australian State and the Australian Capital Territory. A total of 74 (including National Network Members) people participated in the consultation process, drawn from a wide cross–section of the private sector. Ms McMahon reported that all 74 participants consulted unanimously supported the use of a CPoC Measure in private hospital–based psychiatric services. The NRI/MHSIP was thought to be suitable for this purpose by 73 of those consulted, with 1 person abstaining. All 73 people consulted supported the use of an independent third party, for the collection of the NRI/MHSIP, and 73 of those consulted recommended that the proposed trial of the NRI/MHSIP should proceed, with 1 person abstaining. Ms McMahon reported that the National Network would be having a teleconference on 22 March 2005 to discuss the results of the consultation and to make any amendments to the NRI/MHSIP questionnaire.

(c) Proposed Trial of the NRI/MHSIP

The SPGPPS noted that the 10th National Network Meeting had then considered the proposed trial of the *NRI/MHSIP* as outlined in the Project Brief, in consultation with Mr Morris–Yates and Dr Pring. This included discussion of local consultation and reporting processes and the relationship between the MH–CoPES Project and the proposed CPoC Project.

Ms McMahon indicated that the results of the National Network's careful deliberations and consultations had resulted in the firm view that a CPoC Measure should be implemented in the private sector.

Discussion

Ms Suzy Saw and Ms Carole Turnbull advised that caution should be exercised in changing the wording of a validated instrument such as the NRI/MHSIP. It is important that the instrument remains comparable to other instruments and across sectors.

Ms Turnbull then indicated that, while Hospitals are enthusiastic about consumer perceptions of care being measured, they have some concerns regarding the costs associated with the trial and what will happen after the trial, particularly when Hospitals are already paying for and using, the Mental Health Inpatient version of the Press Ganey questionnaire (Press Ganey).

Mr Morris–Yates felt that the majority of Hospitals who use Press Ganey, as part of their routine quality improvement processes should be applauded, as they do so without any external funding. The Press Ganey instrument is, however, a proprietary tool and Hospitals do not have control over the feedback process, and it is not routinely collected. Mr Morris–Yates felt that a parallel process of using a different tool (NRI/MHSIP), which is outcome focussed, would provide Hospitals and consumers with more control over how the information is feed back to them, and enable Hospitals to participate in a process that is consistent with the direction that is being taken generally in mental health.

The ISWG has agreed that the first step is to run a pilot test of the amended NRI/MHSIP and the original to determine whether they provide more useful information than is currently available. Mrs Ruth Carson asked if the Press Ganey had been evaluated. This question could not be answered by the meeting. Mr Paul Mackey supported the pilot as an important process to precede any trial. Ms Suzy Saw stated that the Australian Government, through a policy document, has made a commitment to the development of a national approach to consumer perceptions of care. The Information Strategy Committee (ISC) of the AHMAC National Mental Health Working Group has indicated that this is a project ISC would like jurisdictions to take a lead on. This will provide an opportunity for different ways of trialling such measures. In response to a question from Mr Osborne, Ms Saw clarified that, at present, there is no nationally agreed CPoC measure.

In drawing the discussion to a close, Ms McMahon reported that Mr Morris–Yates had been asked by the ISWG to amend the CPoC Project Brief to remove the external evaluation and to revise the proposal to reflect the possibility of a multi–stage approach involving, initially, a pilot of the NRI/MHSIP.

Mrs Ruth Carson added that the CPoC measure consultation process reflected the investment that consumers and carers had in their participation in the consultation. Mrs Carson felt it would be a pity if this enthusiasm were lost due to lack of subsequent action.

Mrs Judy Hardy complimented the National Network on progress with the CPoC measure to date and raised the question as to whether the National Network had discussed a carer perception of care measure. Ms McMahon responded that the development of such a measure is on the agenda for the National Network to be pursued after the work on the CPoC measure is completed. Dr Lammersma reported that discussions concerning carer perceptions of care were already underway in South Australia and Dr Jonathan Phillips would be able to provide Ms McMahon with further details.

Mrs Hardy felt that, if the potential for synergy was to be realised and duplication of effort avoided in the development of these measures, then close collaboration between the public and the private sectors would be critical concerning the work being undertaken in both sectors. Ms McMahon indicated that the National Network was committed to a high level of communication between sectors. Ms Saw indicated that there would be a national consultation process that the National Network will be able to link into.

The Chair thanked Ms McMahon for the work undertaken on behalf of the National Network in relation to the development of a CPoC measure for use in the private sector.

3.3.2 Other Matters discussed at the 10th National Network Meeting

The SPGPPS noted that the 10th National Network Meeting had also undertaken the following.

- A submission to the *Review of the Medicare and Pharmaceutical Benefits Programs Privacy Guidelines*.
- Discussed how to strengthen consumer and carer representation and participation in private hospitals.
- Developed a policy position on the payment of consumers and carers and their training and further development.
- Developed a template for recruitment process and job descriptions.
- Held discussions with Mr Paul Mackey and the Chair of the APHA Psychiatric Sub–committee, Ms Christine Gee, concerning issues relevant to private Hospitals.
- Developed policy and procedures for responding to improve the responsiveness of the National Network to the call for submissions and presentations.

4 STANDING ITEMS

4.1 AHMAC NATIONAL MENTAL HEALTH WORKING GROUP (NMHWG)

The meeting noted that the last meeting of the NMHWG was held on 7 March 2005 in Auckland New Zealand. The SPGPPS representative on the NMHWG, Dr Yvonne White, reported on the meeting. On several occasions during Dr White's report the meeting expressed concern over some of the timeframes involved for comment on NMHWG documents. Ms Suzy Saw responded and explained some of the reporting constraints the NMHWG must operate under as a Working Group of the Australian Health Ministers Advisory Council (AHMAC). The NMHWG Executive is planning to review all groups established under NMHWG and it is anticipated that this review may result in improvement in processes and timeframes.

The SPGPPS noted the following agenda items from the NMHWG meeting.

Item 2 National Mental Health Policy

A paper concerning a strategy for review of the National Mental Health Policy has been circulated to the Australian Health Ministers Council (AHMC), AHMC has not yet finalised this item.

Item 3.1 Implementation Of The National Mental Health Plan 2003–2008

The NMHWG has endorsed the amended version of the *Implementation Plan for the National Mental Health Plan 2003–2008*. The Implementation Plan will be reconsidered at the 16 June 2005 AHMAC meeting, prior to consideration by Health Ministers in July 2005.

The NMHWG Executive will consider a process for monitoring progress and will provide recommendations to the July 2005 NMHWG meeting. The Executive will consult with the Mental Health Council of Australia (MHCA) regarding the process for monitoring of progress.

Item 3.2 Evaluation of the National Mental Health Plan 2003–2008

The NMHWG has given its in–principle support to the development of an evaluation framework for the *National Mental Health Plan 2003 – 2008*. Option 1 for the management of the evaluation, was endorsed. This option requires the appointment of an independent chair for the

evaluation. The NMHWG also agreed to a more detailed paper being prepared by the Australian Government Department of Health And Ageing (DoHA) for consideration at the July 2005 NMHWG Meeting. The meeting recommended that timeframes be clear in the paper, that cross portfolio involvement, carer and consumer involvement, and private sector involvement must be included in the paper. It was also recommended that the appointment of an additional member to the steering committee be considered to represent the broader social context.

Item 4 NMHWG Safety and Quality Partnership Group (SQP)

The appointment of Dr Peggy Brown as Deputy Chair of SQP was endorsed and the NMHWG noted the update on the *National Standards For Mental Health Services* (NSMHS), including the membership of the NSMHS Subgroup. The NMHWG noted the comment from the SQP that consumer and carer surveyors who have been trained are not being used and requested further clarification from SQP for the NMHWG July meeting**.**

Ms Suzy Saw reported that, under the Free Trade Agreement, the Australian Government is now bound by the Commonwealth Procurement Framework, which means that anything that is considered a covered procurement (essentially over $80,000) must be put to international tender. This has substantially increased the workload for the DoHA.

The NMHWG recommended amendment to the draft *National Action Plan for Safety Priorities in Mental Health* to remove references to indicators and strategies requiring further development by jurisdictions. Following minor amendment, the NMHWG endorsed the draft Plan, in–principle, for distribution for comment. Comments must reach the NMHWG Secretariat by **4 April 2005**. NMHWG Members agreed that in–principle endorsement of the draft Plan did not indicate agreement to monitoring, and requested SQP to provide further clarification concerning monitoring of the Plan. The draft Plan will be tabled at the 9 March 2005 meeting of the Australian Council On Safety And Quality In Health Care (ACSQHC) and considered out of session by the ACSQHC'S State Quality Officials Forum. It was further agreed that the draft Plan be referred to the National Advisory Council on Suicide Prevention and the Quality Use of Medicines Subgroup of the Better Outcomes Implementation Advisory Group for additional specific comment by 4 April 2005. The final document will then be submitted to AHMAC for endorsement**.**

Dr White indicated that the NMHWG would like to receive any specific changes the APHA might wish to make. Dr Pring indicated that he was working with Mr Paul Mackey on those changes and that they would be submitted to the NMHWG Secretariat by 4 April.

Item 5 Information Strategy Committee (ISC) Report

The final draft of the *National Mental Health Information Priorities 2nd Edition* was endorsed by the NMHWG and it was agreed that it should be forwarded to the National Health Information Group for endorsement. It would then go to AHMAC for out–of–session for endorsement.

The NMHWG noted:

- progress with the National Benchmarking Project, in particular the commencement of the nomination process and role of the National Mental Health Performance Sub–committee;
- progress towards developing a national approach to the measurement of consumer perceptions of care;
- the updated terms of reference and 2005 work plan for the ISC and requested minor amendment to the terms of reference; and

- progress towards finalising the evaluation report of the *National Minimum Data Set For Admitted Patient Mental Health Care*, and that a final draft will be submitted to the NMHWG out–of–session.

Item 6 National Co–morbidity Taskforce Update

In relation to the National Co–morbidity Taskforce, the Australian Government agreed to write to the chair of NMHWG to clarify in writing what support can be provided to the Taskforce and any desired outcomes. NMHWG Members agreed to provide comment on correspondence tabled from Drug Strategy Branch of DoHA regarding proposed projects for the National Co–morbidity Initiative. Comments must reach the NMHWG Secretariat **24 March 2005**.

Dr White tabled copies of the correspondence received on 16 March 2005 from the NMHWG Secretariat requesting comments from the SPGPPS on the Initiative. Given the timeframe involved, Dr White requested that comments from the SPGPPS be submitted directly to NMHWG Secretariat Manager, Ms Alison Grant by 24 March.

Item 7 National Promotion and Prevention Working Party (PPWP) Report

Members of the NMHWG have been asked to provide comment on the PPWP, *Pathways Of Recovery: Framework for preventing further episodes of mental illness* document, and its dissemination to the NMHWG Secretariat by **30 April 2005**. The early intervention work will be progressed as part of the new Youth Mental Health Initiative. The PPWP will provide a paper to the July 2005 NMHWG meeting on engaging key stakeholders.

Dr White reported that Professor Beverley Raphael has resigned as Director of Mental Health in New South Wales as of April 2005. Professor Raphael will continue as chair of PPWP for a further six months (review date 7 September 2005).

Item 8 National Consumer and Carer Forum (NCCF)

The NMHWG clarified that the Consumer and Carer Participation Policy is a NCCF document and therefore NMHWG was not required to endorse it. The Policy was, therefore, noted and welcomed by members, rather than endorsed. Members agreed to recommend services and organisations to the NCCF for the distribution of the Policy. Input was requested by **31 March 2005**. Recommendations are to be sent to Chief Executive Officer of the MHCA, Mr John Mendoza, at admin@mhca.com.au.

Item 9 Nursing Workforce Supply Recruitment And Retention

An update was noted by the NMHWG on the implementation of the AHMAC recommendations from the Australian Health Workforce Advisory Committee (AHWAC) report of December 2003 titled, *Australian Mental Health Nurse Supply, Recruitment and Retention*. The NMHWG endorsed the establishment, under the Mental Health Workforce Advisory Group (see Item 10 below), of a small group to work with the Council of Deans of Nursing and Midwifery, to progress the AHMAC recommendations from the December 2003 AHWAC report. Nominees to the group are:

1. Margaret Grigg Victoria
2. Frances Pagdin Northern Territory
3. Ben Nielsen New South Wales
4. Coral Muskett Tasmania
5. Carol Swendson Queensland

Item 10 Workforce Redesign Forum

The NMHWG noted the paper on the Workforce/Workplace Redesign Forum held on Friday, 26 November 2004 in Canberra. It was agreed, in–principle, to establish a NMHWG cross–

jurisdictional Mental Health Workforce Committee to progress the work of the Forum. Dr Ruth Vine will provide draft terms of reference, a work plan and a statement of what is required to support such a Committee out–of–session to the NMHWG.

Dr White reported to the SPGPPS that she had requested that the RANZCP and the RACGP be involved in the Committee.

Item 11 Consumer Operated Services Discussion Paper

The NMHWG consumer representative, Ms Helen Connor, summarised the *Consumer Operated Services Discussion Paper* developed for the NMHWG in March 2005. Members congratulated Ms Connor was congratulated on an excellent and informative paper and further exploration of this model was supported by the NMHWG. The NMHWG recommended the Paper be referred to the Mental Health Workforce Committee (see Item 10 above) and that work should be reflected in the terms of reference for the Committee. At Dr White's request, Ms Connor agreed to provide copies of the Discussion Paper to the Chair of the National Network of Private Psychiatric Services Consumers and Carers. Dr White briefly explained to the SPGPPS how these services operate in the United Sates of America.

Item 12 Mental Health Homelessness and Housing Taskforce (HHTF) Report

The NMHWG agreed to a twelve–month extension to the operating period for HHTF from July 2005, and endorsed a revised work plan for HHTF that includes:

- development of a set of national principles for mental health services regarding homelessness;
- completion of the updated literature review; and
- documentation of current good practice models.

The NMHWG accepted the report titled, *Australian Mental Health Inpatient Snapshot Survey 2004*, and recommended an amendment to acknowledge that the purpose of the survey was to review *access block* in inpatient facilities. It was agreed that the Survey will have limited circulation and not be publicly released. The NMHWG will provide the Survey to the Supported Accommodation and Assistance Program (SAAP) Coordination and Development Committee (CAD), noting it should have limited circulation. It was also agreed that the HHTF should review the methodology of the *Survey* and refer the updated methodology to the NMHWG for reconsideration of a repeat survey.

Item 13 National Practice Standards for the Mental Health Workforce Implementation Group (NPSIG)

The NMHWG noted that NPSIG has appointed Professor Robert Bland as Project Officer tasked to develop a plan to implement the National Practice Standards and it was agreed that private psychiatric sector would be consulted as part of the development of the plan to implement the Standards.

Item 14 Better Outcomes in Mental Health Care Initiative (BOIMHC)

The Chair of the BOIMHC Advisory Committee, Dr Julie Thompson, provided the NMHWG with an update on this initiative and indicated that the May 2005 Medicare Benefits Schedule will include an item for psychiatrists.

The Evaluation of BOIMHC has been completed but is considered confidential and has not been circulated. The Initiative has been involved with the Red Tape Taskforce, which is investigating concerns expressed by general practitioners, and their respective organisations, about administrative burdens associated with compliance with government programs.

The NMHWG noted the 2004 Federal Election commitments for mental health, the current uptake statistics for each of the five components of the BOIMHC initiative, and the national implementation of the GP Psych Support service.

The NMHWG recommended that Dr Thompson work with a small group to develop recommendations for the 1 July 2005 NMHWG meeting on better integration of the BOIMHC initiative with NMHWG. Dr Peggy Brown, Dr Jonathan Phillips, Dr Thompson and Ms Marian Kroon agreed to participate with the Australian Government co–ordinating the discussion.

Item 15 National Disasters and Terrorism Working Group (DTWG) Report

The Chair of DTWG, Professor Raphael, updated the NMHWG on current activity and members expressed thanks to Professor Raphael for her recent work in responding to the Asian Tsunami disaster. Members supported Professor Raphael having an ongoing role as Chair of DTWG and requested that New South Wales continue to report back to NMHWG regarding the activity of DTWG. The SPGPPS noted that Dr White is a member of DTWG

Item 15.2 South Australian Fires

Dr Phillips provided a verbal report to the NMHWG on the impact of the January 2005 fires in South Australia, which led to extraordinary loss of livestock and property and a significant number of lives lost in a small rural community. Dr Phillips was involved in the mental health response as part of the larger cross–government response to the fires. Dr Phillips reported considerable reach in the community with 200 assessments completed for fire–related problems and 950 people reached via community forums. A research strategy has been put in place. Professor Raphael noted that the group she was chairing was developing a Research Plan, which included data sets that can be used across events.

Item 16.1 International Initiative For Mental Health Leadership (IIMHL) Presentation

The NMHWG noted the nominations for Australian representatives on the IIMHL committees and noted that the Australian Government has accepted the NMHWG nominations. The Director of the IIMHL, Mr Fran Silvestri, then reported on a very successful meeting in Wellington in the previous week. Exchanges were organised in 53 sites in Australia and New Zealand and one hundred and seventy three people were involved. Two hundred people attended the Wellington meeting. The June 2006 exchange will be held in the United Kingdom, with a meeting in Edinburgh. As part of the exchange, the host will nominate a problem area and the guest will provide a consultation on this problem. Mr Silvestri outlined the IIMHL Social inclusion project, which will involve 12 sites across 5 countries and will focus on social inclusion. Next year 2 new projects will commence focusing on Children and Families and Cultural issues.

Mr Taylor reported to SPGPPS that Mr Allen Morris–Yates and Ms Janne McMahon had presented at the internal DoHA briefing for Dr Bob Glover.

Ms Suzy Saw spoke to the SPGPPS on the value of being involved in the IIMHL.

Item 17 The Untied States of America, National Association of State Mental Health Program Directors (NASMHPD) Exchange Placement with NMHWG

Dr Sherbon reported to the NMHWG on the very successful placement involving Dr Bob Glover from the NASMHPD and NMHWG. Dr Sherbon will continue dialogue with Dr Glover in a number of areas including the Safety and Quality areas of seclusion and restraint and indigenous issues.

Item 18.2 Mental Health Council of Australia (MHCA)

The Chair of the MHCA, Mr Keith Wilson, reported to the NMHWG that the Human Rights and Equal Opportunity Commission draft report should be available to state bodies in draft for

comments on accuracy during the next week. State and Territory jurisdictions requested that copies of the draft be provided to the relevant NMHWG Members at the same time it is forwarded to Premiers, to facilitate the checking process. This was agreed. The Australian Government requested a copy of the draft report also be forwarded to the Health Priorities and Suicide Prevention Branch at the same time and Mr Mendoza undertook to clarify if this would be possible with the Office of The Hon. Mr Christopher Pyne, Parliamentary Secretary. The final public release of the report is likely to occur in May 2005.

The Executive Officer of the MHCA, Mr Mendoza, reported to the NMHWG on progress of the Memorandum of Understanding (MoU) with seven pharmaceutical companies to work on some specific areas of business.

Dr White explained to the SPGPPS that the initial MoU represented a pilot alliance between the MHCA and the seven companies. Meetings were held with the Alliance members in Sydney on 2 March 2005. Continuation of the Alliance for a further 12 months was discussed along with specific projects for the future collaboration. The SPGPPS noted that the seven companies involved in the alliance are as follows.

1. Eli Lilly Australia
2. Pfizer Australia
3. Wyeth Australia
4. Lunbeck Australia
5. Bristol Myers Squibb Australia
6. Glaxo Smithkline Australia
7. Astra Zeneca Australia

Dr White reported that the specific projects for the initial MoU period were:

Project 1: Production of materials related to MHCA/HREOC Consultation

Project 2: Quality Use of Medicines (QUM)

Project 3: Mental and Physical Health – World Mental Health Day 2004

The NMHWG has noted that the framework is now in place and the next phase will focus on what happens at the market place and how policy is translated into activity. The MHCA would like to expand discussion with the insurance industry to include travel insurance. MHCA will further survey carers and consumers through a project with the University of Sydney with Professor Ian Hickie as the researcher.

Item 18.4 National Advisory Council on Suicide Prevention (NACSP)

The NMHWG noted the current work being undertaken by NACSP including the following.

- Government consideration of priority activities to progress until 2006 under the National Suicide Prevention Strategy.
- Government consideration of membership of the Community and Expert Advisory Forum
- Evaluation of the National Suicide Prevention Strategy
- Life Framework consultations.

Item 18.5 Update on the National Statement of Principles for Forensic Mental Health

The NMHWG has noted progress with the *National Statement Of Principles For Forensic Mental Health* through the Corrective Services Administrators' Conference (CSAC) was noted and the Australian Government undertook to clarify what funding support is available for carer and consumer participation in the Forensic Implementation Group. Dr White reported to SPGPPS that progress is delayed due to CSAC only meeting once a year.

Item 18.6 Information Report from the National Older People's Mental Health Network

The report of the National Older People's Mental Health Network was noted by the NMHWG

Item 19 Other Business

Under Other Business, Dr Sherbon reported that AHMAC would no longer rotate the location of meetings and recommended that NMHWG follows suit and in future meet in Melbourne. Members agreed, but requested further consideration of costs for some states.

The NMHWG thanked Professor Raphael for her contribution to NMHWG and her friendship and wished her well.

Dr White reported that the next NMHWG meeting would be held in Melbourne on Friday, 1 July 2005.

4.1.1 ACCESS TO PSYCHIATRIC BEDS

The Chair then reported that the SPGPPS has been investigating what the barriers are to changing existing practices with regard to private hospitals being able to take involuntary patients. The difficulty with this issue is the differences in mental health Acts across the various States and Territories. Some States specifically exclude private hospitals from taking involuntary patients and others allow it under certain conditions.

In Queensland and South Australian private hospitals can take involuntary patients provided they are registered as approved mental health facilities. Western Australian Hospitals are also allowed by legislation to take involuntary patients, but the regulations governing approval are onerous. The SPGPPS has agreed that this issue should be referred back to the NMHWG for consideration when they are reviewing their legislation, under the argument that disruption to continuity of care is a significant issue. In doing so, the SPGPPS has agreed that it will provide the NMHWG with a clear picture of the scale of the situation of the numbers of detained privately insured patients, in at least one private sector jurisdiction.

Ms Bronwen van der Wal then reported on the results of the SPGPPS Secretariat's investigation of the current situation in Queensland and South Australia, as follows.

South Australia

2001 180 detained with 21 needing transfer to a closed public facility
2002 151 detained with 10 needing transfer to a closed public facility
2003 102 detained with 11 needing transfer to a closed public facility
2004 80 detained with 8 needing transfer to a closed public facility

Queensland
2004 239 detained across the 3 metropolitan hospitals in Brisbane

This information was discussed and it was agreed that the data collected should be passed on to the NMHWG.

> ***RESOLVED (UNANIMOUSLY)***
>
> *That the Strategic Planning Group For Private Psychiatric Services requests the Chair advise the AHMAC National Mental Health Working Group 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. The disruption to continuity of care caused by the current situation is a significant issue particularly given the number of people affected.*

4.1.2 GOVERNMENTAL INQUIRIES

The SPGPPS then discussed the following forthcoming Inquiries and Dr White urged stakeholder to ensure that their constituencies were in a position to respond within the timeframes involved.

(a) Senate Select Committee on Mental Health

The SPGPPS noted that a Senate Select Committee on Mental Health, was appointed on 8 March 2005 to inquire into and report by 6 October 2005 on the provision of mental health services in Australia, with particular reference to:

a. the extent to which the National Mental Health Strategy, the resources committed to it and the division of responsibility for policy and funding between all levels of government have achieved its aims and objectives, and the barriers to progress;

b. the adequacy of various modes of care for people with a mental illness, in particular, prevention, early intervention, acute care, community care, after hours crisis services and respite care;

c. opportunities for improving coordination and delivery of funding and services at all levels of government to ensure appropriate and comprehensive care is provided throughout the episode of care;

d. the appropriate role of the private and non–government sectors;

e. the extent to which unmet need in supported accommodation, employment, family and social support services, is a barrier to better mental health outcomes;

f. the special needs of groups such as children, adolescents, the aged, Indigenous Australians, the socially and geographically isolated and of people with complex and co–morbid conditions and drug and alcohol dependence;

g. the role and adequacy of training and support for primary carers in the treatment, recovery and support of people with a mental illness;

h. the role of primary health care in promotion, prevention, early detection and chronic care management;

i. opportunities for reducing the effects of iatrogenesis and promoting recovery–focussed care through consumer involvement, peer support and education of the mental health workforce, and for services to be consumer–operated;

j. the overrepresentation of people with a mental illness in the criminal justice system and in custody, the extent to which these environments give rise to mental illness, the adequacy of legislation and processes in protecting their human rights and the use of diversion programs for such people;

k. the practice of detention and seclusion within mental health facilities and the extent to which it is compatible with human rights instruments, humane treatment and care standards, and proven practice in promoting engagement and minimising treatment refusal and coercion;

l. the adequacy of education in de–stigmatising mental illness and disorders and in providing support service information to people affected by mental illness and their families and carers;

m. the proficiency and accountability of agencies, such as housing, employment, law enforcement and general health services, in dealing appropriately with people affected by mental illness;

n. the current state of mental health research, the adequacy of its funding and the extent to which best practice is disseminated;

o. the adequacy of data collection, outcome measures and quality control for monitoring and evaluating mental health services at all levels of government and opportunities to link funding with compliance with national standards; and

p. the potential for new modes of delivery of mental health care, including e–technology.

The SPGPPS noted the Senate Committee would like to receive initial submissions by **Thursday, 28 April 2005**. People wanting to lodge a submission after that date should contact the Committee Secretariat to advise that they intend to put in a later submission. The Committee can be contacted at:

Committee Secretary
Senate Select Committee on Mental Health
Department of the Senate
Parliament House
Canberra ACT 2600
Australia
Phone: 02 6277 3034
Fax: 02 6277 3130
Email: mental.health@aph.gov.au

Further information concerning the Inquiry can be obtained from the website address at:

http://www.aph.gov.au/senate/committee/mentalhealth_ctte/index.htm

Dr White reported that the AMA has invited her, as the Chair of the SPGPPS, to participate in its deliberations concerning the development of the AMA submission. The question was raised as to whether the SPGPPS would be making its own submission to the Committee. After discussion, it was agreed that the SPGPPS would not make a submission, but rather that the work of the SPGPPS should be brought to the attention of the Committee.

Mr Osborne reported that the AHIA will be making a submission and is in the process of drafting a briefing document scoping the sector. The AHIA would be happy to share relevant information arising from that scoping exercise.

Mr Lovelock advised that, in preparing their submissions, stakeholders would be wise to share what information they can in an effort to achieve some consensus as to the five or so high level key principles and directions the private sector might want the government to adhere to. This would provide a good basis for discussion in the Senate, particularly when the Terms of Reference are so broad.

Mr Osborne felt it would be important for all those making submissions to think about the sort of questions they may be asked by the Senate and address those as part of their submission.

Dr Nothling supported these suggestions and indicated that it may require a private sector roundtable. The SPGPPS noted that Dr Nothling has discussed this approach with the President of the AMA. Dr Nothling sought support of those present for this approach. The meeting was generally supportive of an AMA roundtable, but felt it should be timed to enable those

organisations invited to have prepared their draft submissions. The middle of April was thought to be suitable.

Dr Lammersma and Mrs Hardy advised on the approach that will be taken by the MHCA in preparing its submission.

In drawing this item to a close, the Chair suggested that the non–government stakeholders contact the Senate Committee Secretariat directly and request an extension for submission if they experienced difficulty in meeting the 28 April deadline for submission.

RESOLVED (UNANIMOUSLY)

1. *That the Strategic Planning Group For Private Psychiatric Services (SPGPPS) requests that the Chair write to the Senate Select Committee on Mental Health to advise the Committee on the work of the SPGPPS, its Centralised Data Management Service, and the National Network for Private Psychiatric Sector Consumers and Carers.*
2. *That the SPGPPS requests that its Australian Medical Association (AMA) Representative, Dr Martin Nothling, to advise the Association that the SPGPPS is supportive of the AMA convening a roundtable of private sector stakeholders in mid–April to share information concerning submissions to the Senate Select Committee on Mental Health.*

(b) House of Representatives Standing Committee on Health and Ageing Inquiry into Health Financing

Dr White then reported that, as a result of the House of Representatives Standing Committee on Health and Ageing's review of the 2003–2004 annual reports of the DoHA and the Private Health Insurance Administration Council, the Committee resolved, on 16 March 2005, to conduct an inquiry. The Committee has invited interested persons and organisations to make submissions addressing the terms of reference by **Friday, 6 May 2005**.

The SPGPPS noted that the Terms of Reference for the Inquiry are as follows.

The Committee shall inquire into and report on how the Commonwealth government can take a leading role in improving the efficient and effective delivery of highest–quality health care to all Australians.

The Committee shall have reference to the unique characteristics of the Australian health system, particularly its strong mix of public and private funding and service delivery.

The Committee shall give particular consideration to:

(a) examining the roles and responsibilities of the different levels of government (including local government) for health and related services;

(b) simplifying funding arrangements, and better defining roles and responsibilities, between the different levels of government, with a particular emphasis on hospitals;

(c) considering how and whether accountability to the Australian community for the quality and delivery of public hospitals and medical services can be improved;

(d) how best to ensure that a strong private health sector can be sustained into the future, based on positive relationships between private health funds, private and public hospitals, medical practitioners, other health professionals and agencies in various levels of government; and

(e) while accepting the continuation of the Commonwealth commitment to the 30 per cent and Senior's Private Health Insurance Rebates, and Lifetime Health Cover, identify innovative ways to make private health insurance a still more attractive option to Australians who can afford to take some responsibility for their own health cover.

In order to facilitate electronic publishing of submissions, the committee has requested that they be emailed to haa.reps@aph.gov.au, or sent on disk to the Secretariat at:

Committee Secretary
Standing Committee on Health and Ageing
House of Representatives
Parliament House
Canberra ACT 2600
Ph: 02 6277 4145
Fax: 02 6277 4844

Further information concerning the Inquiry can be obtained from the website address:

http://www.aph.gov.au/house/committee/haa/healthfunding/index.htm

Following discussion, it was agreed that this Inquiry was particularly relevant to the work of the SPGPPS and that a submission should be made to the Inquiry, with the Australian Government abstaining.

RESOLVED (UNANIMOUSLY)

That the Strategic Planning Group For Private Psychiatric Services (SPGPPS) requests its Members and Observers to forward any comments they might wish to have included in a submission to the House of Representatives Standing Committee on Health and Ageing Inquiry into Health Financing, to the SPGPPS Secretariat. Comments should be submitted in accordance with the Terms of Reference for the Inquiry.

(c) National Inquiry into Employment and Disability

Dr Lammersma asked that the SPGPPS note that Dr Sev Ozdowski, Human Rights Commissioner and Acting Disability Discrimination Commissioner, will conduct on behalf of the Human Rights and Equal Opportunity Commission an inquiry into equal opportunity in employment and occupation for people with a disability in Australia.

The purpose of the inquiry is to:

- identify existing systemic barriers to equal employment opportunity for people with disabilities;
- examine data on employment outcomes for people with disabilities including workforce participation, unemployment and income levels; and
- examine policies, practices, services and special measures implemented to advance equal employment opportunities for people with disabilities.

It was noted that the scope of the inquiry includes Commonwealth government as an employer and service provider; and private sector employers. The inquiry will report in November 2005 and is particularly interested in hearing from:

- employer groups and individual employers
- people with disabilities
- community groups who represent people with disabilities
- disability service providers
- government agencies
- employment services
- unions.

The Inquiry would like to hear about:

- personal employment experiences, from the perspective of employers and employees
- views about barriers to employment, from the perspective of employers and employees; and
- ideas about how to overcome these barriers in a practical and efficient manner.

Dr Lammersma reported that the Inquiry has published four initial *Issues Papers*, which will help focus attention around specific questions. The papers discuss the following.

Issues Paper 1: *Employment and disability: The statistics*

Issues Paper 2: *Employment and disability: The issues for people with a disability*

Issues Paper 3: *Employment and disability: The issues for employers*

Issues Paper 4: *Employment and disability: Commonwealth Government assistance*

Copies of the Issues Papers and further information can be obtained at the website:

www.humanrights.gov.au/disability_rights/employment_inquiry/index.htm

The SPGPPS noted that initial submissions are requested by **Friday, 15 April 2005**. Submissions can be emailed to: employmentinquiry@humanrights.gov.au, or sent in hard copy to:

Employment Inquiry
Disability Rights Unit
Human Rights and Equal Opportunity Commission
GPO Box 5218
Sydney NSW 2001

Dr Lammersma indicated that the RANZCP will be putting in a submission and would welcome any comments SPGPPS Members and Observers might wish to make.

4.2 HOSPITALS REPORT

Hospital representatives advised that they had no other issues to raise beyond those covered under other agenda items today.

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 some minor changes be made to make the guidelines more generic for use in both Australia and New Zealand. Dr Lammersma anticipated that the guidelines would be revised and represented to the May 2005 meeting of the RANZCP General Council. Once approved, the guidelines will be a public document.

Dr Brian Kable reported on a related development under the BOIMHC Initiative whereby there had been some discussion around the difficult issues of the development of an MBS Item where the mother and child could be treated as a conjoint group in a general practice setting.

4.3.2 General Practice Liaison Workshop and New MBS Item

Dr Lammersma reported on the General Practice Liaison Workshop held on 28 January 2005. Representatives from the RANZCP, RACGP, Australian Divisions of General Practice (ADGP) and the Australian Government attended.

The Workshop discussed the practical issues to do with how liaison between these groups can be improved. Australian Government representatives at the Workshop indicated that the new consultation MBS Item for psychiatry had been approved and there was a discussion of how to ensure that Item is utilized. The Workshop suggested that there should be utilisation training for the MBS Item. The RANZCP will be putting a submission to the Australian Government for the funding of a training package, which will include a video and related training materials. The RANZCP will be approaching the Minister for Health and Ageing to launch the training package at the forthcoming RANZCP Congress to be held in late May 2005. The President of the RACGP will also be invited to participate in the launch. As part of the implementation of the new MBS Item, the Australian Government is funding a three–month trial of the Item through the South Australian Divisions of General Practice. The trial commences after Easter. The RANZCP is also in the final stage of negotiations with the Australian Government concerning the implementation of state–based referral directories, which will provide GPs with access to information about the various psychiatric sub–specialities and where their practitioners can be found.

Mr Harry Lovelock reported on the joint release between the RANZCP, the Royal Australian College of Physicians, and RACGP, of a clinical guidance statement on the use of Selective Serotonin Re–uptake Inhibitors (SSRIs) for children and adolescents.

4.3.3 AMA Position on E–health record

Dr Martin Nothling reported that in it's consultation process with the Australian Government on the ultimate development of a national electronic health record, the AMA considered that access to a reliable, historical record of an individual's encounters with the health system throughout their lifetime can contribute to safety and quality in the delivery of health care. The national approach to e–health, while complex and as yet in a state of flux, is consistent with the AMA objective of a unified approach, which has until now been sadly lacking.

Dr Nothling indicated that, in accordance with its submission to the Office of the Federal Privacy Commissioner, the AMA considered that the major priority is to gain public confidence that e–health records are protected from privacy invasion. New sources of information provided by data linkages, while creating the potential for significant positives in health management, also create risks in compromising patient and practitioner faith in the integrity of the system. Dr Nothling indicated that the AMA considered that any proposal to relax the privacy guidelines in this regard would be counter–productive.

Dr Nothling then spoke about the National E–health Transition Authority (NEHTA), which was established in early to mid 2004 as a forum in which e–health could be developed and tasked with driving work that was key to the development of the building blocks of a national system such as clinical terminology, patient and provider numbers and provider directories. HealthConnect, the main Australian Government body dealing with e–health in the last three years, under the management of the Information and Communication Division of the DoHA, is to be reviewed and possibly restructured. Dr Nothling reported that the AMA's current understanding is that the implementation–monitoring role would move to NEHTA. One clear message that is coming from the DoHA is their intention to move from a *demand* rather than a *supply* approach to E–health.

Dr Nothling indicated that the AMA had further concerns about the PBS and the MBS Privacy Guidelines in that the AMA has argues the case for a functional separation between the MBS and the PBS databases to limit data linkage. While the issue is not yet resolved the AMA recent submission on this issue indicated that developments in information and communications technology has created a significantly greater potential for privacy intrusion through data linking. In that context, it is of more importance today that the law, and in particular the MBS and PBS Privacy Guidelines, continue to stringently protect the separation of MBS and PBS data. In light of current technological development and the potential risks to privacy from a greater capacity for data linkage, there may in fact be case for strengthening the Privacy Guidelines.

Dr Pring added that head of NEHTA had indicated publicly that one of his first tasks would be to ensure that in standardizing the electronic ways in which health professionals communicate, and in all the proprietary systems that are set up, the possibility of intercommunicating information is addressed. Dr Pring felt that this was an area in which the Australian Government could take the lead in terms of regulating some standard ways of operating that might allow industry to actually move forward in a positive way.

4.4 GENERAL PRACTITIONER REPORT

The Chair then invited the RACGP Representative, Dr Brian Kable, to report on any current issues relevant to general practitioners, which require consideration or action by the SPGPPS.

Dr Kable indicated that the RACGP had been working with the RANZCP on the roll out of the training package for the new MBS Item Number and the state–based referral directories as per Dr Lammersma summary under Agenda Item 4.3.2 above.

Dr Kable reported that in the lead up to the 2004 Federal Election the Coalition Government gave a commitment to continue and expand the BOIMHC Initiative. Ms Suzy Saw indicated that this included a funding increase of $30 million over 4 years, which would enable expansion of the Initiative to address new issues. In addition, a new funding of $50 million over four years was committed to address mental health. Dr Kable reported that a national evaluation of the Initiative had been completed but that the Advisory Committee for the Initiative has not yet seen the evaluation report.

Dr Kable reported on the Mental Health Standards Collaboration is proceeding with the implementation of the new Standards. The Collaboration continues to approve courses and ensure the Standards are adhered to. The smooth running of these operational processes has enabled the Collaboration to service other parts of the Collaboration's terms of reference, which include promulgating the initiative among GPs. The new Standards were implemented at the beginning of this year, which is a new triennium for GP training. The new Standards for Level 1 and Level 2 courses have been implemented. The SPGPPS noted that the Collaboration has rejected three courses so far on the grounds that they do not meet the consumer and carer element of the Standards. The Collaboration has also been fortunate in getting Level 1 training into registrar training programs for GPs. The collaboration is also approaching the Deans of Medical Schools to look at linking the Level 1 type training with undergraduate psychiatry training. Mental health training should be a seamless part of medical training. The Collaboration is now auditing courses to ensure they are achieving their objectives and undertaking a lot more public relations work. The Collaboration is also looking at the issue of remote areas. Dr Kable provided statistics on the uptake for Level 1 and level 2 training and it was noted that well over 4,000 GPs were registered for Level 1 and over 800 GPs registered for Level 2. This is twice what was originally projected for Level 1. Distribution of uptake was also noted. Dr Kable reported that the Collaboration is seeing a large increase in the amount of mental health CPD type training that GPs are undertaking separate to this.

Dr Kable indicated that he had presented recently at the World Family Doctors Congress in Orlando concerning the Initiative and there was a lot of interest from Welsh and Irish GPs who are trying to set up a similar initiative and are going to use the Australia as a model.

Dr Kable indicated that he and Professor Ian Wilson are also linked into the World Organisations of Family Doctors, which has a special interest in psychiatry. Dr Kable reported he had also appeared on the SBS Insite television program on depression.

The SPGPPS noted that Dr Kable has also been approached by a newspaper to discuss the perennial problem of people with a mental health problem being unable to obtain insurance.

In response to a question, Dr Kable indicated that Level 1 training enables GPs to access the MBS Items for the 3 Step Mental Health Process and requires a minimum of six hours training on assessment, planning and review. Level 2 training enables GPs to deliver Focussed Psychological Strategies to their patients and claim the relevant MBS Items. It involves at last 20 hours of training in Focussed Psychological Strategies, which are mostly Cognitive Behaviour Therapy (CBT), or Interpersonal Therapy, based.

Dr Nothling reported that the AMA Budget Submission had called for increased funding for mental health area particularly in relation to general practice, indigenous health and long term care for disabled. Dr Kable reported that not much appears to be happening in the indigenous health areas so the Collaboration is pushing ahead with work in this area.

4.5 HEALTH FUND REPORT

The Chair then invited the Health Fund Representatives, Mrs Judy Hardy and Mr Brian Osborne, to report on the following two issues that remain outstanding from the 37th Meeting of the SPGPPS.

4.5.1 Electroconvulsive Therapy (ECT)

Mr Osborne reported that the RANZCP Guidelines on ECT had been sent to all Health Funds and the AHIA. Any further complaints will be dealt with on a case–by–case basis and should be forwarded to Mr Osborne and Mrs Hardy. Dr Lammersma reported that the RANZCP had not received any further complaints.

4.5.2 Medical Reports to Health Funds

Dr Lammersma indicated that this issue was initiated by 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. The correspondent was concerned over two issues. Firstly, that this information goes to a Health Fund administrative officer, or someone who may not be bound by confidentiality. The second concern was that someone without any medical training appears to be making the decision concerning the extension of funding for Day Programs.

Mr Osborne responded to the correspondents first concern and indicated that all Health Fund personnel must conform to privacy legislation. In relation to the second concern requests for extension of Day Programs only occur where there are limits on those Programs in the first place. Mr Osborne was not aware of how many Health Funds still have those limits in place, but he suspected the numbers would be fairly small. Dr Lammersma indicated that it is not only requests for extensions of Day Programs where this practice occurs. Health Funds also require such information, for example, when a request is made for extension of an in–patient program.

Mr Osborne responded that, in effect, the clinician is asking for additional funding. On that basis, a Health Fund would want to know the Health Fund Members details, the length of stay, or number of service already delivered, the extra services required, and the expected outcome. Dr Lammersma responded that in the case under discussion, the Health Fund had requested highly specific personal and medical details about the patient, their condition, and treatment. Mr Osborne agreed to follow this up with the Health Fund concerned. The meeting agreed that Mr Osborne should be provided with the details of the case under discussion.

> ***RESOLVED (UNANIMOUSLY)***
>
> *That the SPGPPS requests 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. The SPGPPS Secretariat is asked to provide a copy of the original correspondence received by the RANZCP for Mr Osborne.*

Mr Peter Callanan indicated that this issue was highly relevant to the current discussion being undertaken in the DoHA, Private Health Industry (PHI) Branch in relation the use of the new claim form for private patients for use in both public and private hospitals, and 3B Certificates. Essentially, the situation has risen whereby some Health Funds, unwittingly, are going to directly to the hospitals to obtain information. The 3B Certificate requires, however, that it is the patient or their guardian that gives the doctor permission to release the information, not the hospital. Patients are unaware that the hospital is providing the information to the Health Fund. In view of the current privacy legislation, it will be necessary for the Australian Government to establish a policy to address this situation. Mr Osborne indicated that there are times when Health Funds have to go through the hospitals to obtain information, as Health Funds do not collect information on who a patient's doctor is.

4.6 AUSTRALIAN GOVERNMENT REPORT

Australian Government representatives advised that they had no other issues to raise beyond those covered under other agenda items today, except to bring to the SPGPPS attention that the

Guidelines for Determining Benefits for Health Insurance Purposes for Private Patient Hospital–based Mental Health Care are now due for their annual review.

It was agreed that SPGPPS Representatives would take the current Guidelines back to their respective constituencies and advise the next meeting as to whether the Guidelines required review again this year. If not, it was agreed that the Guidelines could be re–stated and circulated.

RESOLVED (UNANIMOUSLY)

That the SPGPPS requests 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 the 40th Meeting of the SPGPPS as to whether the Guidelines require review in 2005.

5. OTHER BUSINESS

5.1 WORLD PSYCHIATRIC ASSOCIATION SECTION OF EPIDEMIOLOGY AND PUBLIC HEALTH MEETING

Dr Pring reported that the World Psychiatric Association Section of Epidemiology and Public Health Meeting will be held in Brisbane on 5/6/7 July 2005 and it was noted that Mr Morris–Yates will be attending the Meeting.

Mr Taylor reported that Professor Harvey Whiteford, had given advance notice, via email, that, as part of the WPA Meeting, he will be convening a session on the afternoon of Thursday, July 7 on the proposed National Mental Health Policy for Australia. Professor Whiteford is keen to have as many of the key players in Australia as possible present and is hoping someone from the SPGPPS might be able to find time to attend at least that day of the conference and participate in the session.

5.2 SPGPPS FORUM 2005

After discussion, it was agreed that it would not be necessary to hold an SPGPPS Forum in 2005.

6. NEXT MEETING

The next meeting of the SPGPPS will be held on **Friday, 24 June 2005** at the New Farm Clinic, 22 Sargent Street, New Farm, Queensland. The meeting will commence at 9:30 AM and conclude at 4:00 PM.

The *SPGPPS Dinner* will be held on **Thursday, 23 June 2005** from 7:00 PM onwards at *Lat. 27 Bistro*, 471 Adelaide Street, Brisbane.

7 CLOSE

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

Dr Yvonne White
SPGPPS Chair

Mr Phillip Taylor
SPGPPS Executive Officer