STRATEGIC PLANNING GROUP FOR

SPGPPS

PRIVATE PSYCHIATRIC SERVICES

THIRTY SEVENTH MEETING

HELD AT
PERTH CLINIC
29 HAVELOCK STREET WEST PERTH
WESTERN AUSTRALIA
ON
FRIDAY, 10 SEPTEMBER 2004

REPORT OF MEETING

Glossary of Acronyms and Terms used regularly 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
DVA	Australian Government Department of Veterans' Affairs
GP(s)	General Practitioner(s)
HCP	Hospital Casemix Protocol
Health Fund(s)	Private Health Insurance Fund(s) that pay benefits for psychiatric care
HoNOS	The Health of Nation Outcome Scale instrument being used in the private sector consisting of 12 items measuring behaviour, impairment, symptoms and social functioning
HSMdb	Hospitals Standardised Measures database application
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
MHQ–14	The self–report measure being used in the private sector consisting of 14 items related to issues associated with mental and behavioural problems drawn from the SF–36.
National Model	The SPGPPS National Model for the Collection and Analysis of a Minimum Data Set with Outcome Measures for Private, Hospital–based Psychiatric Services
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–Seventh (37th) SPGPPS Meeting was held on Friday, 10 September 2004 at the Perth Clinic in Perth, Western Australia.

1. PROCEDURAL MATTERS

1.1 OPENING/WELCOME/APOLOGIES/PROXIES/GUESTS

In the absence of the SPGPPS Chair, Dr Yvonne White, the SPGPPS Deputy Chair, Ms Moira Munro, 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 Jo Lammersma — Proxy for Dr Yvonne White

Australian Medical Association (AMA)

2. Dr Martin Nothling — Proxy for Dr White failing Dr Lammersma
3. Dr Bill Pring — (Observer)

Australian Government (AG)

4. Ms Suzy Saw — Department of Health & Ageing, Health Priorities & Suicide Prevention, Proxy for Mr Peter Callanan and Mr David Morton.

Consumer Representative

5. Ms Janne McMahon — Chair, National Network

Carer Representative

6. Ms Ruth Carson

Royal Australian College of General Practitioners (RACGP)

7. Dr Brian Kable

Private Hospitals with Psychiatric Beds (Hospitals)

8. Ms Moira Munro — Deputy SPGPPS Chair and proxy for Sue Williams

Private Health Insurers (Health Funds)

9. Mrs Judy Hardy
10. Mr Brian Osborne

SPGPPS Secretariat

11. Mr Phillip Taylor — SPGPPS Executive Officer
12. Mr Allen Morris–Yates — SPGPPS Principal Information Officer
13. Ms Bronwen van der Wal — SPGPPS Administrative Officer

Invited Observers

14. Mr Peter Groves — Health Funds HBF Representative, AHIA Mental Health Committee
15. Ms Christine Gee — Hospitals, Chair APHA Psychiatric Sub–committee

Apologies

1. Dr Yvonne White — SPGPPS Chair
2. Ms Sharon Brownie — RANZCP (Observer)
3. Mr Peter Callanan — Department of Health and Ageing, Private Health Insurance
4. Ms Katherine Bates — Department of Health and Ageing, Private Health Insurance
5. Ms Sue Williams — Hospitals Representative
6. Mr David Morton — Department of Veterans' Affairs (DVA)

Proxies

The SPGPPS Executive Officer, Mr Phillip Taylor, reported that in her absence, Dr Yvonne White, had appointed Dr Jo Lammersma (and failing her Dr Martin Nothling) as proxy to vote on her behalf at this meeting.

Ms Sue Williams has, in her absence, appointed Ms Moira Munro as proxy to vote on her behalf.

Mr Peter Callanan, in his absence, has appointed Ms Suzy Saw to vote on his behalf.

Mr David Morton, in his absence, has appointed Ms Suzie Saw to vote on his behalf.

Mr Taylor then indicated that the following Representative Members present at the 37th SPGPPS Meeting were entitled to vote as follows.

Representative Member(s)		Vote Entitlement
RANZCP	Dr Yvonne White Dr Jo Lammersma	Apology 2 votes (proxy for Dr White)
AMA	Dr Martin Nothling	1 vote
RACGP	Dr Brian Kable	1 vote
CDHA	Ms Suzy Saw Ms Peter Callanan	3 votes (proxy for Mr Callanan and Mr Morton) Apology
DVA	Mr David Morton	Apology
Hospitals	Ms Moira Munro	2 votes (proxy for Ms Williams) + 1 casting vote
Health Funds	Mrs Judy Hardy Mr Brian Osborne	1 vote 1 vote
Consumers	Ms Janne McMahon	1 vote
Carers	Mrs Ruth Carson	1 vote
Total Votes		10 (excluding the Chair's casting vote) of a possible 13

1.2. REPORT OF THE 36TH SPGPPS MEETING

The meeting approved the draft report of the 36th SPGPPS Meeting held on 11 June 2004 in Brisbane, Queensland.

RESOLVED (unanimous)

That the Strategic Planning Group For Private Psychiatric Services (SPGPPS) approves the Report of the 36th SPGPPS Meeting, held on 11 June 2004 in Brisbane, 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 36TH SPGPPS MEETING

The SPGPPS noted and updated the following Progress Report on Actions Arising from the 36th SPGPPS Meeting and discussed any out–of–session decisions.

	Agenda Items	ACTION OFFICER (S)	STATUS
	Report on the 36th SPGPPS Meeting		
➢	Draft and circulate report of 36th Meeting for comment	Secretariat	Done
➢	Revise Report based on comments received and prepare final	Secretariat	Done
➢	Agenda Item 37th SPGPPS Meeting	Secretariat	Done
2	Report on the 35th SPGPPS Meeting and Planning Day		
➢	Post Report on the SPGPPS website	Secretariat	Done
2.1	SPGPPS Finance Committee (FC)		
➢	Mr Chris Keegan to replace Dr Jo Lammersma as the RANZCP Representative	Secretariat	Done
➢	Letters to Mr Keegan and Dr Lammersma	Secretariat	Done
➢	Organise 2nd Quarter FC Meeting	Dr Nothling/Secretariat	18 August
➢	Agenda Item 37th SPGPPS Meeting	Secretariat	Done
2.2	SPGPPS Operating Guidelines		
➢	Amend Guidelines based on comments of the 36th SPGPPS Meeting	Secretariat	Done
➢	Issue 21 written notice of the intention to repeal the Guidelines at the 37th SPGPPS Meeting	Secretariat	Done
➢	Agenda Item 37th SPGPPS Meeting	Secretariat	Done
3.1	Innovative Models Working Group (IMWG) Report		
➢	Re–covene IMWG prior to 37th SPGPPS	Mr Taylor/Secretariat	28 July
➢	Agenda Item 37th SPGPPS Meeting	Secretariat	Done
3.1.2	Review of IMWG Terms of Reference (TOR)		
➢	Prepare a revised version of the TOR for consideration at the 20 July EO Teleconference	Secretariat	Done
➢	Hospitals to prepare presentation for 37th SPGPPS Meeting	Ms Munro/Ms Williams	**38TH MTG**
➢	Consumer and Carers to prepare presentation for 37th SPGPPS Meeting	Ms McMahon/Ms Carson	Done
➢	Hospital and Consumer and Carer presentations to Secretariat by Friday, 27 August 2004	Secretariat	Done
3.2.1	Psychiatric Admissions to Non–Psychiatric Private Hospitals		
➢	Prepare material for ISWG	Mr Morris–Yates	*Pending*
➢	ISWG to progress this issue	ISWG	*Pending*
3.3	Substance Abuse and Dependency Working Group Report		
➢	Obtain copies of the Alcohol Resources Brochure for SPGPPS	Secretariat	Done
➢	Reconvene Working Group to review membership and progress recommendations	Mr Morton/Secretariat	11 August
➢	Agenda Item 37th SPGPPS Meeting	Secretariat	Done
4.1	Name Change for SPGPPS		
➢	SPGPPS Members/Observers to consult constituencies and report back to 37th SPGPPS.	SPGPPS	Done
➢	Agenda Item 37th SPGPPS	Secretariat	Done
4.2	Public Private Sector Integration		
➢	SPGPPS Chair to progress with AHMAC NMHWG initially at 2 July 2004 NMHWG Meeting	Dr White	Done
4.3	Access to Psychiatric Beds		
➢	Letter to State and Territory Health Authorities	Dr White/Secretariat	Done
➢	Agenda Item 37th SPGPPS Meeting		Done
6	Next Meeting		
➢	Organise 37th SPGPPS Meeting at the Perth Clinic	Secretariat/Ms Munro	Done
➢	Organise SPGPPS Dinner 9 September in Perth	Secretariat/Ms Munro	Done

The meeting noted that there were no other matters arising from the last meeting of the SPGPPS that were not covered under appropriate agenda items for this meeting.

2. FINANCIAL AND OPERATIONAL MATTERS

2.1 SPGPPS FINANCE COMMITTEE

The Chair reported that the third (3rd) meeting of the SPGPPS Finance Committee was held on Wednesday, 18 August 2004 via teleconference at 6:00 PM and noted that a copy of the draft report of that meeting had been circulated with the agenda and papers for the 37th SPGPPS Meeting. The Chair of the Finance Committee, Dr Martin Nothling, spoke to the report.

Ms McMahon reported that there may be a small overspend at the end of the year due to the rollover of partial funding. Ms McMahon indicated that the current annual budget of $35,900 would increase to $41,000 in 2005.

Dr Nothling reported that the Committee is satisfied that the pattern of spending for the first and second quarters of 2004 for SPGPPS, CDMS and the National Network.

RESOLVED

That the Strategic Planning Group For Private Psychiatric Services (SPGPPS) notes the draft Report of the Third SPGPPS Finance Committee Meeting, held on 18 August 2004 via teleconference.

2.2 SPGPPS OPERATING GUIDELINES

The Chair then asked the meeting to consider and, if appropriate, endorse the draft *SPGPPS Operating Guidelines*, which were further revised by the SPGPPS Legal Counsel, Ms Jane Ferry, in consultation with the SPGPPS Secretariat following the 36th SPGPPS Meeting. A copy of the revised Operating Guidelines had been circulated with the agenda and papers for this meeting.

The SPGPPS Executive Officer, Mr Phillip Taylor reported he had issued 21 days written notice, via email, to all members of the SPGPPS of the possibility that the Operating Guidelines could be repealed or amended by resolution of three quarters of Representative Members of the SPGPPS voting, in person or by proxy, at this meeting.

In considering the Operating Guidelines, Consumers and Carers requested that the meeting support amendment of clause 8.4.10 and clause 8.4.11 as follows.

> 8.4.10 One Carer, nominated by the National Network to represent Carers. The nominee will be the current independent Chair of the National Network if that is their status, or a member of the National Network. If the National Network is unable to nominate an appropriate person, then the appointment of an appropriate person, with sufficient expertise, shall be at the discretion of the SPGPPS.
>
> 8.4.11 One Consumer, nominated by the National Network to represent Consumers. The nominee will be the current independent Chair of the National Network if that is their status, or a member of the National Network. If the National Network is unable to nominate an appropriate person, then the appointment of an appropriate person, with sufficient expertise, shall be at the discretion of the SPGPPS.

The suggested re–wording of these clauses was incorporated into the Guidelines and the following motion was then put to a vote of Representative Members present.

MOVED (Dr Lammersma) **SECONDED** (Dr Nothling)

That the Strategic Planning Group For Private Psychiatric Services (SPGPPS) endorses the SPGPPS Operating Guidelines September 2004, as amended by the 37th SPGPPS Meeting, and requests that Executive Officer issue a twenty one day written notice for the commencement of the SPGPPS Operating Guidelines September 2004. All earlier versions of these Guidelines will then be rendered null and void.

The motion was declared **CARRIED** unanimously.

The meeting then proceeded to the next item of business.

3. WORKING GROUP REPORTS

3.1 SPGPPS INNOVATIVE MODELS WORKING GROUP (IMWG)

The Chair then asked the meeting to consider the self–explanatory draft report of the 9th IMWG Meeting, which had been circulated with the agenda and papers for this meeting and invited the Chair of the IMWG, Mr Phillip Taylor to speak to the report. Mr Taylor reported that the 9th IMWG Meeting was held on Wednesday, 28 July 2004 via teleconference. Following discussion, Mr Taylor sought the endorsement of the SPGPPS for the Terms of Reference.

RESOLVED

That the Strategic Planning Group For Private Psychiatric Services (SPGPPS) notes the draft Report of the 9th SPGPPS Innovative Models Working Group (IMWG) Meeting held on 28 July 2004, and endorses the revised IMWG Terms of Reference, as follows:

1. *Review what work has been undertaken in relation to innovation in service delivery for private sector mental health services and determine what can be learnt from such work.*
2. *Identify innovative models of service delivery and the funding arrangements that would be required to enable their uptake.*
3. *Consider the obstacles to achieving innovation in service delivery.*

Mr Taylor reported that the 36th SPGPPS Meeting requested that its Hospital representatives prepare a presentation concerning their views on innovative models of service delivery for this meeting of the SPGPPS. Mr Taylor indicated that this presentation had been deferred to the 38th SPGPPS Meeting in November. Psychiatrists had agreed to present their views instead. Mr Osborne indicated that Mr David Morton had been scheduled to present a paper on funding of mental health services to the Veteran Community at the 36th meeting of the SPGPPS. Unfortunately Mr Morton was an apology at that meeting. The meeting agreed that Mr Morton should be asked to present to the 38th Meeting of the SPGPPS in November.

The SPGPPS Chair then invited Dr Bill Pring to address the meeting on private psychiatrists perspectives on innovative models of service delivery.

3.1.1 PSYCHIATRISTS PERSPECTIVES ON INNOVATIVE MODELS OF SERVICE DELIVERY

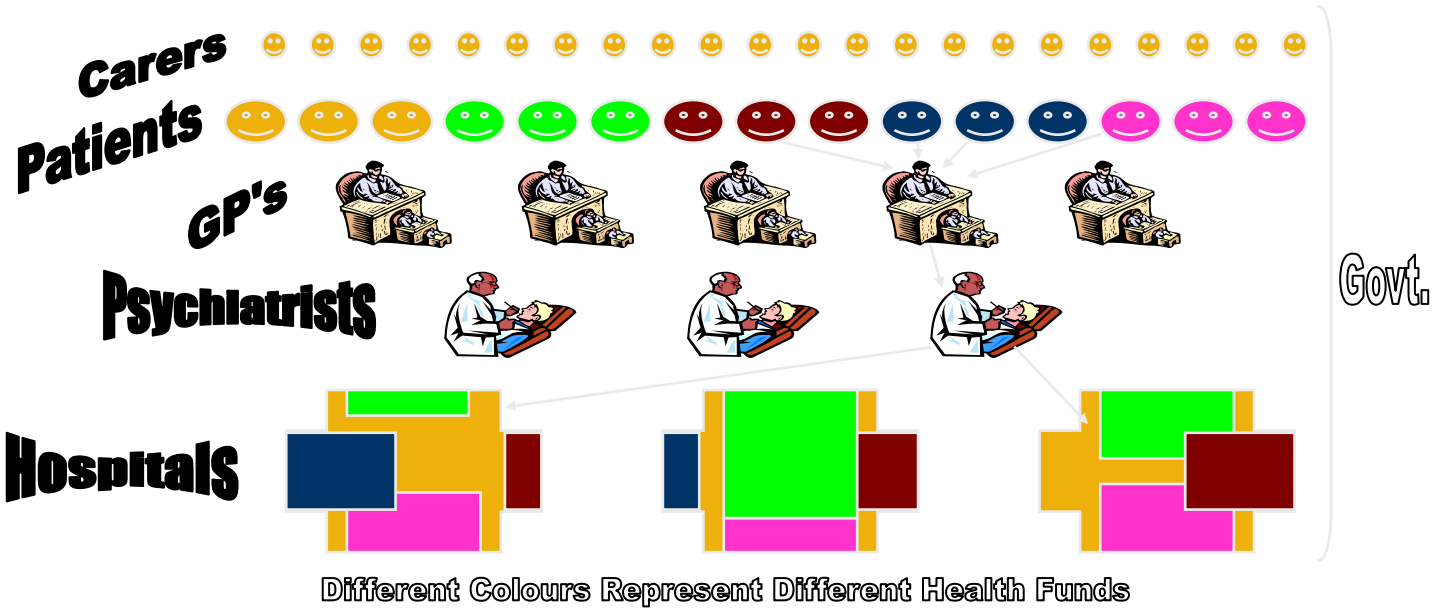
Dr Pring indicated that as background to the subject of Innovative Models, he thought it might be helpful to go back to basics and question what we are talking about with innovation. Dr Pring posed the question of why should we innovate at all? What do we need to innovate? What evidence is there of where the problems are that would give clear directions as to where to innovate.

The perception is that health funds have largely led this debate, and in many ways, the health funds should be congratulated for being willing to drive possibilities for change in the sector; and possibly the rest of the sector has been somewhat complacent in not initiating any momentum towards discussion about the possibility of change or progress in the sector. The health fund emphasis seems to have had an economic focus, and the initial attempt at Innovative Model development seemed to falter. Since that attempt to implement new models of care seemed to fail, maybe it is worth going back to basics, and asking what is the real need to innovate?

Dr Pring indicated that the wish to innovate could arise for a number of different reasons, which could include cost containment, greater efficiency, incorporation of new information technology processes, implementing more community based treatment, or perhaps to improve patient treatment overall. Overall, Dr Pring concluded that cost containment and the provision of more community services seem to be the principles guiding innovative models of service so far. Dr Pring suggested that for the process of innovation, it is necessary that the evidence for change is presented clearly, a decision is made on what we wish to change, research of the options for change are undertaken, consensus on a pathway is achieved and then changes are implemented.

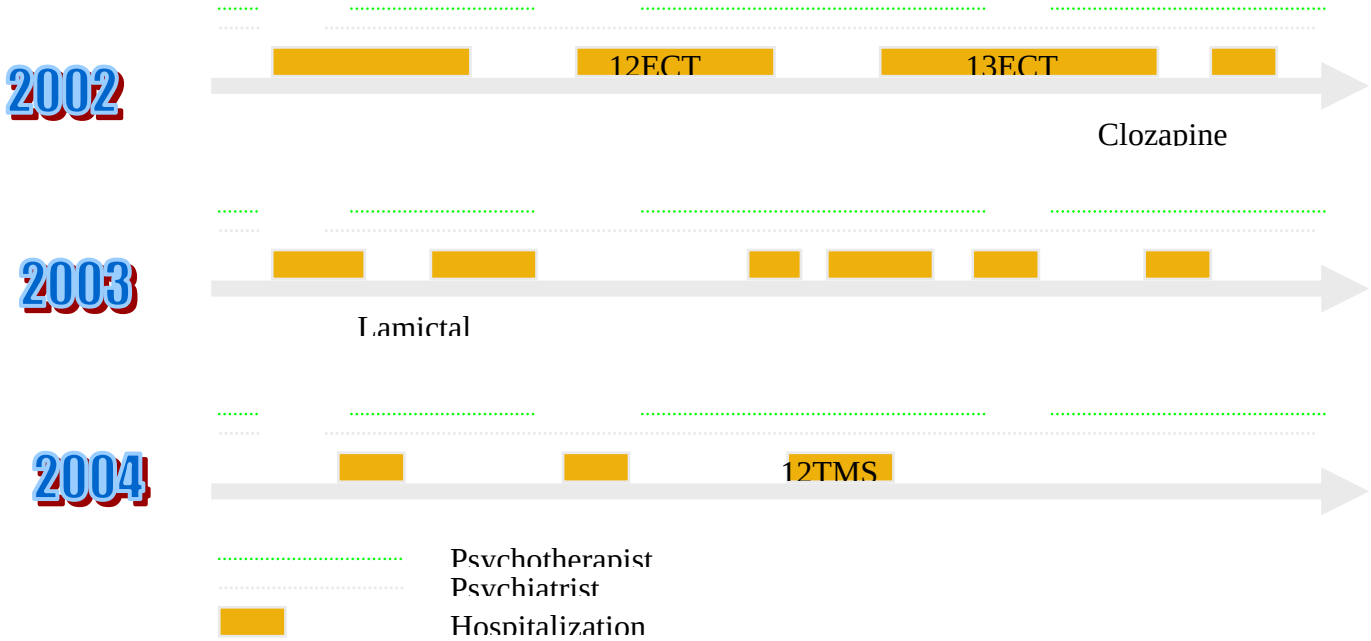
The Private Mental Health Sector as a Complex System

Dr Pring outlined the layers of interaction in the mental health system, that reveal its complexity. Behind the 300,000 patients there are at least a million carers. Patients with and without membership of a number of different health funds are linked to general practitioners. General practitioners refer selected patients to psychiatrists with affiliations with one or a number of private psychiatric hospitals. The private hospitals have various contractual arrangements with different health funds, and the care delivered in the hospital is a combination of the work of the psychiatrist and other health professionals in the hospital. The Government, through Medicare, funds much of the cost of medical care from the general practitioner and psychiatrist, both in the community and in hospital.



Patients and carers expect certain treatment and support options from the system. General practitioners expect service from the private psychiatrists. Hospitals try to provide appropriate services for the patients that are treated by them, and have to satisfy the demands of the funders. Health funds and government have certain expectations of private psychiatrists and hospitals. Dr Pring suggested that it would be worthwhile examining the literature on complex systems in order to think coherently about the issues surrounding innovation in what is a very complex system. For example, a change to a small part of the system may lead to unexpected and even counter–productive outcomes in other parts of the system, if the whole system and how it functions is not understood. Dr Pring advised that his presentation could be made available electronically.

One Patient's Partial Complexity:



Dr Pring, through the diagram above, outlined the complexity of one patient's treatment over three years. This description does not take account of other factors going on in the patient's life such as ceasing work or living with parents at some time during this period, emphasizing how difficult it is to accurately pin down all the elements involved that impact on the primary aim of mental health services, the treatment of the patient.

Dr Pring indicated that there are several 'layer's' of consumers of psychiatrist's services. The psychiatrist's patients are the most obvious but there are also the patient's families, concerned about the service provided to the patient, the GP wanting to refer a patient, the Hospitals, wanting the psychiatrist to utilize their service and the health funds and government, who want a good quality service at the lowest possible price.

How can Professionals and Corporations successfully co–operate?

Dr Pring pointed out some of the differences between a professional based practice and a corporate management practice. Professionals value the independence of the individual practitioner in being able to further the interests of the patient in a relatively unfettered way. The professional aspires to more capable function based on the body of applied knowledge accumulated by that profession, and which is a knowledge base greater than the evidence–based knowledge base alone. Ethical principles are emphasised in professional practice, and the therapeutic relationship with the patient is crucial to the treatment process. A longitudinal and holistic view, is valued by most healthcare professionals.

Corporations are non–living entities where people are brought together to achieve core business functions based on professional management principles. In most corporations there tends to be a significant emphasis on the economics of the business, and there can be a variable focus on ethics in corporations, often driven by the particular corporate culture. There tends to be an emphasis on corporate responsibility and a de–emphasis of individual responsibilities. It is worth looking at the ethical strengths and weaknesses of any particular healthcare model one might like to consider. When professionals are unethical, it has a big effect on a small number of patients concerned. When a corporation indulges in unethical behaviour, there is a moderate effect on a large number of people.

The Case for a Per Diem Fee for Service with a Variable Co–payment

The Australian public mental health sector is an example of a corporate mental health care structure under government regulation, and often incorporating regulated area–based competition between health corporate entities. Corporate sector–wide aberrations such as the serious mental illness restriction, and lack of sufficient community–based services during de–institutionalisation, are examples of the inadequacies of a predominantly corporate approach in the mental health sector. The fee for service payment system used by private psychiatrists is often the subject of criticism by funders, both government and private. However, there are certain advantages to the fee for service system, which are often overlooked. The private psychiatrist has the potential to provide the best possible care to the patient on an individualised basis, and can act in the best of circumstances as a type of case manager, helping to direct other forms of care to that person. It is not often recognised how the psychiatrist can engage in what might be called micro–economic charitable adjustment. The psychiatrist can charge a higher fee to people who are more able to pay those fees because they are in adequate employment, and this can then support discounting of those people who are financially disadvantaged. The psychiatrist is often in a much better position to assess the true economic circumstances of the patient than a government bureaucracy. There is another strength in the potential mutual responsibility that occurs, where a patient is making a co–payment in the fees that are received by the psychiatrist. When the patient pays an amount out of their own pocket, they are usually much more inclined to scrutinise the type of services they are receiving, to determine whether they are obtaining sufficient value from them.

Because of the extensive statistical accounting that occurs through the Health Insurance Commission, it is possible for statistical accountability to be used to act as a safeguard in the operation of the fee for service system. Already such statistical accountability seems to be far in excess of most corporate entities. So perhaps, a combination of professional, micro–economic healthcare delivery, with corporate and specifically focused healthcare delivery, may deliver the best of both worlds. Already, hospitals and psychiatrists seem to have found a satisfactory working equilibrium. It is not always comfortable for a hospital to not be in charge of the prime referral source to its facilities.

However, through close working relationships over a period of years, mutual respect and mutual positive influence can occur. Such mutually beneficial working relationships are occurring across Australia year by year. The fact that mental healthcare delivery in our private sector is diversified in this way is likely to produce a strength and stability to our system. We should be cautious about major changes in one or other components of our system, because it may have unexpected consequences in other areas of the mental healthcare delivery system. It would be wise to consider the whole system when considering any changes.

Deep Knowledge of Patients is vital before change

If any changes to the mental healthcare delivery system are made, it would be prudent to have a deep understanding of the needs of our patients, and what sort of changes might be most beneficial. It seems important to ask our patients what sort of changes they would like to see, and that this should be a first step. It is important to use information from other sources as well, and then to do a walkthrough of the scenarios that arise in terms of models of change. It is also important to ask carers what they think of those scenarios.

From a psychiatrist's point of view, we have a certain perception about what our patients may wish for. That is not a patient–based perception, but nevertheless may have some value. Experience with our patients would indicate that they would like a quick expert response from us and minimum upheaval to their lives, both at home and at work. They wish for a good outcome, but there may be many other things that they would wish for that we have not properly listened to or become aware of. We can obtain information from the CDMS database concerning the sort

of conditions that our patients suffer from when admitted to hospital. The most common diagnostic cause for admission to our private hospitals is a mood disorder, and it could be valuable to look in more detail at the needs of a person suffering from a mood disorder in the longer term. We would then be attending to the specific and long–term needs of one of the largest user groups of our hospital–based services, and any improvements we could institute would benefit a large number of people. Another group of people that might benefit from a specific focus on improved care, would be those that could be classed as so–called "outliers", because they are using services to a larger extent. A professional's view of this would be that this is not one class of people, that the information about these people is probably not so well collected, and that these people may require different types of care than the majority of people in our system.

A Path to Innovation

Psychiatrists might therefore suggest a possible pathway to Innovative Model development within our sector, which is more comprehensive than that proposed up until now. We would suggest a more extensive process of consultation with patients and carers to define what extra services they would like to see in our sector. Then we would need to design processes to meet those needs, accounting for complexity in the system as a whole, and the likely longitudinal results in patient outcome. We can consider what the best mix of professional and corporate provided services might be in meeting those needs, and then perform a "What If" scenario analysis to see what the results in our complex system might be. Finally, it would be important to consider the appropriate financial structure to support such planned innovation, and an appropriate implementation strategy would follow.

Problems with Health Fund Suggestions

Dr Pring acknowledged the valuable contribution of the private health funds in initiating discussion about innovative change. By leading with their own ideas first, they have exposed those ideas to greater scrutiny, and they have shown leadership in our sector as a result. Nevertheless, there are some difficulties that psychiatrists might see in the suggestions the health funds have made so far. Most of the models proposed, seem to have a strong financial emphasis within them, which is to be expected from the leading financial underwriter of our sector. Dr Pring did not believe that the funds have given very detailed evidence to support the need for change, and he encouraged further discussion about the actual statistics which demonstrate the cost of mental health within the private sector, and the growth in cost of our sector compared to other sectors, and the relationship of that growth in cost to wages growth within the health sector. The health fund models did not elucidate any significant linkage to psychiatric practice and, whilst that is natural, given the health funds' predominant relationship with hospitals, previous analysis of the complexity of the sector indicates the need for some consideration of the total system. An analysis of the ethical or "moral hazards" would seem to be an important additional means of evaluating models suggested, which has been absent from debate so far.

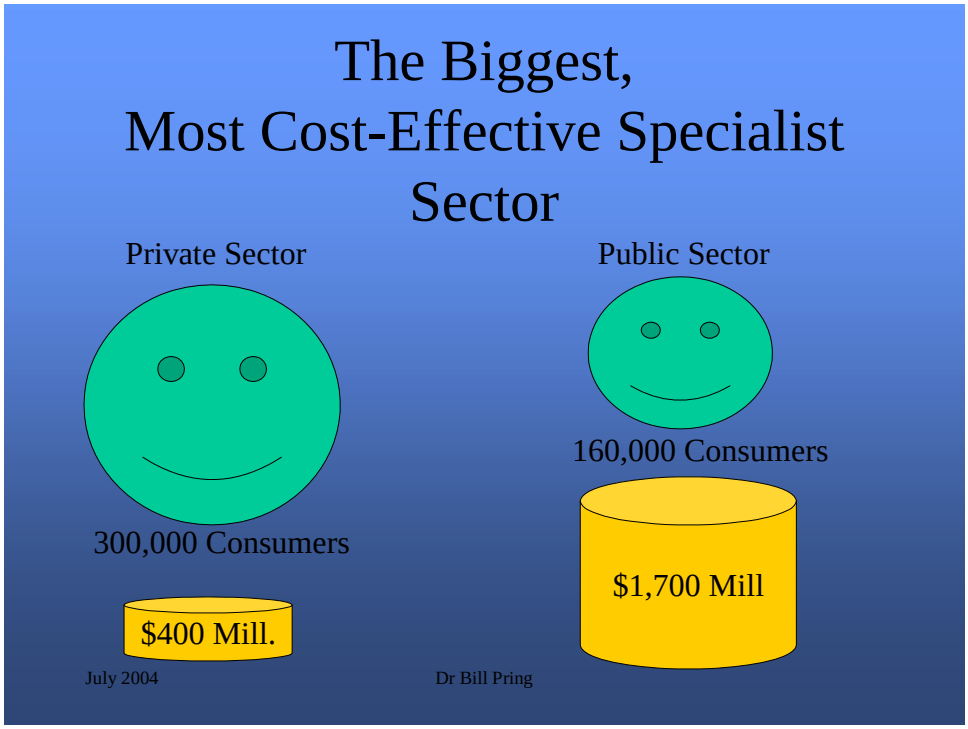
The **programme–based payment model** would seem to have similar problems for health funds as other programmes run by hospitals, and which have been criticised in the past by health funds. There is a possibility for programmes to develop a life of their own, and soak up funding, without adequate safeguards against cost blow–out, and without adequate evaluation of outcomes compared to a more generic–based treatment process. If programme–based payment was to predominate, there may be a constriction of other services, which do not entirely fit within any of the programmes that the hospital system may then be providing. There would seem to be a difficulty for outlier patients who are not likely to neatly fit within any particular programme structure.

The **prospective payment model** seems to work in South Australia under near–monopoly conditions, and it is questionable whether the model would work in other State situations.

Sharing the profits from cost saving within that model, by both health funds and hospitals, could lead to a very significant potential "moral hazard", by encouraging decreased services on the basis of cost. There is likely to be a constriction of services with time under this model. Such models are also highly likely to stifle future innovations, even if some innovations are encouraged in the initial phase of model implementation. Any such model would have to include a very significant component for negotiation of remuneration based on population changes with time. From public sector experience, such negotiations seem not to occur in a timely way, and are very difficult to conclude adequately.

The **case management model** may potentially work with very chronic mental health problems, or outlier patients. Such a model adds another cost layer to the health delivery system, and such increased cost may not actually save money overall, especially with time. In the United States, such case management models, which have included utilisation review, have been shown to potentially add cost and lead to poor outcome. There is strong potential in this model for inter–professional conflict between non–medical case managers and private psychiatrists. Private psychiatrists, with sufficient constructive input, may be able to act as more effective case managers of the same population that may be targeted under such a model.

Cost–Wise, it's hard to get much more Efficient



Maybe per diem plus

There is information, which shows the enormous cost efficiency of the private sector in relation to the public sector in Australian mental health. Such great cost efficiency cannot be explained solely as related to the specialist services provided by the public sector. Dr Pring contended that the cost efficiency is related to the interesting and complex mix between professional–based and corporate–based practice and suggested that the current mix is near to its optimum in terms of cost containment, and that any Innovative Model development which might change the system as it presently exists, is likely to result in very significant cost increase over time. It is acknowledged that innovation and improvement of services in the private sector must be possible, but the appropriate method of producing such changes should take into account the efficiency of this complex system, and is unlikely to be achieved by a corporate takeover of the

sector, even if that could be achieved to a partial extent. It is suggested that the ideal financial way forward could be a maintenance of the existing mix of professional and corporate services, with less separation between the health funds' approach to trying to control hospital costs and the health funds' relationship with the professional sector. Health funds cannot expect to control the professional sector very easily, but, by working in a more encouraging and positive way with the professional sector, they may be able to achieve results that they could not achieve in any other way. It may be possible for funds to spend relatively smaller amounts of money on projects in co–operation with psychiatrists, directed towards achieving aims that are of benefit to health funds. Plans to offer assistance with patients who have been high utilisation outliers may be an example, and indeed this was the basis of the relatively successful Victorian Mental Health Project trial. Large gains may also be made by further improvement in the quality delivery of care for large patient population groups within the sector, such as those suffering from mood disorders. Perhaps there could be a more open review of how much health funds should be spending on mental health within the total private health insurance cake. There is evidence–based knowledge to indicate that psychiatric services, which are provided to general health patients, can save significant amounts of money, and lead to better health outcome for those patients. This is an area that has not been adequately explored by our sector up until now.

Discussion

There was some discussion around programs that would be most beneficial to the two largest groups of consumers of mental health services, outliers – high users of the system and those with mood disorders, Dr Pring pointed to the highly successful Victorian Mental Health Project trial, which offered a specialized program to high users of mental health services (outliers) as an example of an innovative program, which was popular with patients and their treating psychiatrist and saved money. Dr Lammersma reported that the Ellen Frank *Social Rhythms Therapy*, a non–pharmacological approach looking at diet, sleep daily routines and the right amount of stimulation, has high acceptance among consumers with mood disorders. Mr Allen Morris–Yates suggested that a vital part of innovation was the identification of proven effective treatments and thereafter their promulgation with appropriate funding.

Ms Suzie Saw questioned the notion that innovation was being unnecessarily restricted to specific funding models and specific programs rather than first developing a conceptual base. Ms Saw indicated that exploring the concept of service innovation involved, in the first instance, examining the options of changes to funding, system design, and broadening the base of services.

Dr Kable suggested that it was important to consider the system design before considering how it could be practically funded. Dr Kable further commented that it was important to move away from systems, which became hamstrung because of concerns about including everyone. Outliers should be dealt with separately and as exceptions.

Mr Brian Osborne suggested that innovation was primarily about asking psychiatrists what they need to treat patients to a better standard, consumers and carers what services they want, Hospitals what services they can provide in terms of staff and programs, funders to tell us what they can afford and the Government to tell us about the regulatory aspects in terms of being able to change the regulations in a timely manner. Mr Osborne indicated that Health Funds have used funding models to drive change.

3.1.2 CONSUMER AND CARER PERSPECTIVES ON WHAT THEY WOULD LIKE TO RECEIVE FROM HOSPITAL–BASED SETTINGS.

The SPGPPS Chair then invited the SPGPPS Consumer and Carer Representatives, Ms Janne McMahon and Ms Ruth Carson to address the meeting on what services consumers and carers would like to receive from hospital–based settings. Ms McMahon reported that this issue had been discussed extensively at the last face–to–face meeting of the National Network held in

Melbourne on 23/24 August 2004. Ms McMahon outlined the consumer and carer perspective as follows.

Challenges to the Service Providers and Funders

Ms McMahon considered that the challenge to the service providers was to be able to answer the basic questions of; can consumers and carers get what they ask for, is there a funding model that can support their desired outcomes and do they have the support of their treating Psychiatrists, Hospitals and Health Funds?

Rehabilitation Services

Ms McMahon reported that the National Network supports models of care that will encourage the development of coping skills to enable consumers to face the challenge of living with mental illness. The sorts of programs consumers are seeking are not complicated. Programs teaching meditation to reduce anxiety, or the value of exercise for reducing anxiety are what consumers want to be given. These models would support and facilitate recovery or stability to improve quality of life by offering programs, which deal with living skills, functioning in the family context, in the community, and life activities. Consumers and carers would like to see models of care, which incorporate complementary therapies such as meditation and massage and offer recreational and graded exercises such as organized walks, yoga, tai chi. Such models should support groups and recreational activities that are consumer driven and promoted. It is not always possible, for example, to sit through a structured activity when unwell or on new medication. Above all, models of care should enhance social rehabilitation thus reducing isolation and loneliness, major barriers to recovery Ms McMahon emphasized that many facilities are already offering such programs.

Drop – in Service

Ms McMahon reported that the National Network would like to see the development of a non–threatening model that promotes active participation in social and vocational rehabilitation and enhances the quality of life through alleviation of isolation, aloneness and loneliness that often accompanies mental illness. The Network would like to see regular support services in an environment that provide necessary help, social confidence and well being to tackle life instead of hospitalization. A drop–in service would help enormously in the difficult task of re–joining society. Ms McMahon indicated that perhaps with greater uptake of capitation and prospective payment models, these services could be introduced.

Family Therapy Services

Mental illness places massive and negative stressors on relationships particularly partner relationships. Medications can interfere with a large range of personal issues. Consumers and carers would like to see models of care that promote and support family relationships, particularly with partners.

Greater Access to Psychologists

Ms McMahon reported that consumers and carers would like to see improved accessibility and availability of psychologists in hospital–based settings. Psychologist–run models can be of great benefit, particularly for disorders where treatment is time consuming, and may require behavioural therapy such as: Obsessive Compulsive Disorder, Agoraphobia, Social Phobia, and Panic Disorder etc.

24–Hour 7–Day Access

Consumers and carers would like much better access to on call/mobile crisis intervention services, for example, a dedicated help line that provides access for consumers, carers, and other

family members. Ms McMahon pointed out that though these services are available in the public sector, access to those services by those who see a private psychiatrist may be denied in practice, because the system is over burdened and these consumers are regarded as privileged.

Outreach or Community Services

The National Network considers that outreach services should be available in all hospitals, or a model of care that allows access to one provided by another facility.

The Network is also concerned that there be outreach services that go beyond metropolitan areas and include rural and regional areas. Rural and remote regions are the most deprived of private sector services. Ms McMahon commended the 17 Hospitals who have approved outreach services and the Health Funds, which support them.

Ms McMahon emphasised that the role of the carer must be kept in mind in the process of transferring models of care from predominately in–patient settings to out–patient settings. In effect, these programs shift a substantial burden of care from the facility to the unpaid carer.

Diversional Therapy

The National Network considers that models promoting creative arts (not basket weaving) as part of the therapeutic process are important, particularly when the patient is too unwell to participate in structured activity.

Dialectical Behavioural Therapy

Ms McMahon referred to models such as the *Marsha Linehan* treatment modality for people living with personality disorders and life skill issues. There is a real need for providers and funders to support services found to be effective, particularly when it helps those whose suffering is intense.

Acute–Phase Support Groups

Consumers and carers consider that support provided in a group environment during the initial or acute phase for consumers is crucial to treatment outcomes. Ms McMahon acknowledged that many hospitals are doing this and these services are being funded.

Ms McMahon reported that the National Network suggests there should be a separate support group for carers during the initial or acute phase. The Network wants more recognition of the carer by all stakeholders.

Case Managers

Consumers and carers would like case managers attached to hospitals to oversee the consumer's treatment and well being as part of the continuity of care, particularly for those who do not qualify for outreach, or community services post discharge.

Preventative Health

Service providers should provide health education programs such as quit smoking, substance abuse, and weight management. Weight management is important given that weight gains are a common side effect to some medication, which has a depressant effect on patients.

Appropriate Follow–up Services

Consumers and carers want models of care that actively follow up consumers post discharge to reinforce gains made. Ms McMahon pointed out that not everyone goes home to a positive and supportive environment and that other strategies may be needed to sustain the gains made in Hospital.

More Effective Discharge Services

Ms McMahon reported that the National Network wants discharge services, which offer greater consumer and carer involvement and group activity, contain discharge sheets incorporating diagnosis and treatment plans, and contain more information on mental health support services in the community. The latter should also include how and where to access information such as self help tapes, support groups, books on recovery and relapse prevention.

Carer Support and Education Services

The National Network is particularly keen to see in models of care a greater emphasis on communication, education and support for carers. This could include education about the mental illness recognition and involvement in admission and discharge processes, for example, a copy of the management plan provided to a consumer–nominated third party (carer).

Discussion

Dr Kable drew attention to the Better Outcomes in Mental Health Care Initiative (BOIMHC), where currently 700 GPs have undertaken level 2 training and where the patient accessing the BOIMHC is eligible for up to 6 psychological sessions at no cost, and in difficult cases, a further 6 sessions may be allocated. Dr Kable indicated that there needed to be greater emphasis on shared care between the GP, psychiatrist and the Hospital, underpinned by suitable funding arrangements and legislation. Ms Ruth Carson commented, in support of Dr Kable's point, that there is a need to improve linkages. Many of the models of care that private sector consumers and carers would like to see are available in the public sector.

Ms Carson indicated that the National Network's wish list of services underlines the tensions between consumers and carers, given that so much information and facilities are not made available to the carer because the carer has not been sanctioned by the consumer. What is required is a professional acknowledgement of the role played by the carer in maintaining the consumer in the community setting and professional guidelines and support on how to do this effectively.

Mr Osborne reported that in contact with the Australian Divisions of General Practice, (ADGP), GPS had indicated that they would like to become more involved in provision of mental health services as the case manager but lacked the time and resources. Dr Lammersma reported that many psychiatrists act as case managers. Dr Nothling reported that involving the carer in the treatment addressed the case management aspect for many psychiatrists.

Ms Christine Gee indicated that the challenges of innovation of services in the private sector were compounded by the fact that the 44 facilities in the sector are not linked in any way and realistically should be seen as 44 separate businesses. Some Hospitals have nearly all the services consumers and carers want, some Hospitals have some of the services and some have very few. The challenge is to have the more progressive facilities assisting other facilities. Dr Pring indicated that psychiatrists as a group are also not co–ordinated.

Mr Osborne suggested that the National Network prioritise the top three issues that they would like to see progressed.

The Chair indicated that these presentations would be informing the work of the IMWG and it was noted that the next meeting of the IMWG is scheduled for 10 November 2004.

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 has met as follows.

1st ISWG Meeting 20 February 2004 (via teleconference)
2nd ISWG Meeting 11 March 2004 (Sydney)
3rd ISWG Meeting 10 June 2004 (Brisbane)
4th ISWG Meeting 9 September 2004 (Perth)

The Chair asked the meeting to note the draft report of the 3rd ISWG Meeting, which had been circulated with the agenda and papers. The Chair of the ISWG, Dr Bill Pring, was then invited to report verbally on the 4th ISWG Meeting, held on 9 September 2004 to coincide with this meeting of the SPGPPS. In doing so, the Chair also requested that the meeting consider any recommendations arising from the 3rd and 4th ISWG Meetings that might require the endorsement of the SPGPPS. Dr Pring reported on general progress with the ISWG General Work Goals 2004.

Dr Pring reported that the ISWG is looking at the development of protocols for aggregate statistical analyses that, rather than being based on episodes of care as the subjects of analysis, are based on each (unidentified) patient's combined history of episodes of care within a specified reporting period as the subjects of analysis.

Dr Pring also reported that the ISWG had noted that the Private Hospitals Association of Queensland hosted a Forum on 27 July 2004 titled, *Utilising CDMS Data for Clinical & Business Management: An Interactive Forum for Private Psychiatric Hospitals Managers*. This Forum was well attended and coincided with the APHA Psychiatric Sub–committee meeting and seven of nine Committee members and all the States except Victoria were able to attend. Presentations from Toowong, New Farm Clinic and the Perth Clinic on how the CDMS data can be used were all well received and feedback to date has been very positive. The Forum has led ISWG to consider the feasibility of a "roadshow" style of approach for next year.

Dr Pring also discussed the development of outcome measures of consumer and carer satisfaction, to address their perceptions of care, and their perceived needs. A robust discussion resulted in the ISWG Hospital Representative, Ms Moira Munro, agreeing to ask the Australian Private Hospitals Association to consider conducting a survey to ascertain whether private hospitals with psychiatric beds see any merit in a national measure of consumer and carer perceptions of care. Ms Janne McMahon, agreed to ask the National Network of Private Psychiatric Sector Consumers and Carers the following questions in relation to consumer and carer perceptions of care.

- What issues do consumers and carers want measured?
- What sort of qualities do they want to know about?
- Do consumers and carers currently have access to patient satisfaction surveys used by private hospitals with psychiatric beds?

Dr Pring reported on the Key Performance Indicators development process through the AHMAC National Mental Health Working Group Information Strategy Working Group (ISC). Ms Munro, the SPGPPS representative to the ISC has been invited to be a member of the group overseeing this development. The AHMAC National Mental Health Working Group Information Safety and Quality Partnership Group (SQP) is looking at developing a safety key performance indicator.

Reviewing and perhaps redrafting the National Standards for Mental Health Services in a year or two's time was also discussed.

3.2.1. Risk Management Strategies for the SPGPPS National Model and CDMS

In relation to the review of risk management strategies for the SPGPPS National Model and CDMS, Dr Pring and Mr Taylor reported that Mr Morris–Yates had met with the Director AMA Medical Practice Department, Mr John O'Dea and the AMA Legal Counsel, Ms Pamela Burton, on 20 July 2004 to discuss the possible exposure of the AMA to damages arising from the products and services provided to participating Hospitals, Payers and the Australian Government by the SPGPPS's CDMS. Mr Taylor reported that meeting had agreed that there was a possibility, albeit unlikely, that legal action could be taken against the AMA if information provided by the CDMS was relied upon in commercial negotiations and it was subsequently shown to be inaccurate, and reliance on that information had caused some commercial injury. Whether this action was against all members of the SPGPPS, which supervises the CDMS, or the SPGPPS Principal Information Officer as an AMA employee, the final action would be against the AMA per the indemnity arrangements in the *AMA Agreement for Services 2004–2006* and the AMA vicarious liability for its employees. On that basis the AMA agreed to take the following actions.

1. Clarify with the AMA insurers specifically that they would provide comprehensive unqualified cover to the AMA in circumstances where the SPGPPS Information Officer carried out their particular CDMS duties under the direction of the SPGPPS, as specified in the AMA Agreement, both now and after any new arrangements relating to waivers are approved by the SPGPPS. Mr Taylor reported that following a telephone meeting with the insurers, Vero profin had provided the following written confirmation via an email dated 3 September 2004.

   > *It is to be noted that the "Professional Services" description of the above mentioned account acknowledges those data collection and reporting processes noted within "The SPGPPS National Model for Data Collection and Analysis" reference Section 8. Implementation, Clause 8.1 Overview as being within the Insurers capacity as a "professional association representing the medical profession, publishing company and the provision of member services" subject to the current Terms, Conditions and Exceptions for the insurance period from 4pm (local standard time) 23rd March 2004 to 4pm (local standard time) 23rd March 2005.*

2. Develop a form of words which represent a waiver of legal responsibility for the AMA in relation to the provision of CDMS reports to participating Hospitals, Payers and the Australian Government, which can be included in all relevant products and services provided by the CDMS, regardless of the use to which those reports are put.

3. Submit the form of the waiver, and its intended purpose and effect, to the SPGPPS for approval to make it clear that the SPGPPS fully supports the inclusion of the waiver in CDMS products and services.

4. In the event that the SPGPPS is unable to reach agreement and endorse the form of the waiver, or its intended purpose and effect, the AMA should pursue that formal user acceptance testing be included in the processes of the SPGPPS's CDMS and made a part of the waiver provisions in Clause 19 of the AMA Agreement.

5. The AMA should engage legal counsel with appropriate commercial law experience to draft any future agreement necessary if the life of the SPGPPS or CDMS is continued beyond the life of the current agreement. An obvious change would be to the indemnity provisions to ensure a more even distribution of legal responsibility.

Mr Taylor reported that Mr Morris–Yates subsequently wrote to the SPGPPS explaining that the preparation and distribution of the SPGPPS CDMS Standard Quarterly Reports would be delayed pending resolution of this matter and recommending that a disclaimer be included in the covering letters distributing CDMS material to hospitals, health funds and other payers, highlighting the limits for which the material should be used. It was further recommend that the full legal disclaimer be included in appropriate terms at the commencement of each CDMS report.

The SPGPPS was asked to respond by 20 August 2004 and endorse the wording proposed in the covering letter to hospitals, health funds and other payers regarding CDMS information and also to endorse the wording of the disclaimer to be included in the CDMS reports themselves. Dr Pring reported that the responses received were discussed at the 4th ISWG meeting. Based on those responses the ISWG endorsed the disclaimer for the CDMS Standard Quarterly Reports and agreed that inclusion of a disclaimer in the covering letters for the Reports was unnecessary. Dr Pring then put the following motion to the 37th SPGPPS Meeting, which was unanimously endorsed.

RESOLVED (unanimous)

1. *The Strategic Planning Group for Private Psychiatric Services (SPGPPS) notes the report of the 3rd SPGPPS Information Strategy Working Group (ISWG) Meeting held on 10 June 2004 in Brisbane, and the recommendations arising from the 4th ISWG Meeting held in Perth on 9 September 2004.*

2. *That the Strategic Planning Group for Private Psychiatric Services (SPGPPS) endorses the following disclaimer and requests the SPGPPS Information Officer, Mr Allen Morris–Yates, include this disclaimer in statistical reports and, where appropriate, other material produced by the SPGPPS Centralised Data Management Service.*

> "Disclaimer
>
> The SPGPPS has made every effort to ensure that the information contained in this report is free from errors and omissions, and that all the data and information drawn upon to compile it have been provided in good faith. However, the SPGPPS does not warrant the accuracy of the report and does not warrant its suitability for use for any management or commercial purpose. The report is provided by way of information only to aid initiatives to improve the quality, effectiveness and efficiency of private sector hospital–based psychiatric services."

Now that this issue had been resolved, Mr Brian Osborne asked when Hospitals and Health Funds could expect to receive the delayed CDMS Standard Quarterly Reports for the last Quarter 2003 and First Quarter 2004. Mr Morris–Yates reported that CDMS Standard Quarterly Reports would be available by the end of September 2004 and that Health Funds and Hospitals would receive separate Quarterly Reports.

3.2.2 Psychiatric Admissions to Non–Psychiatric Private Hospitals

Dr Pring reported that, in 2003, the SPGPPS Information Officer, Mr Morris–Yates, had provided some preliminary data on national separations of psychiatric admissions from non–psychiatric private hospitals for the 2000–2001 financial years. While Health Funds and other stakeholders were aware of such occurrences, at best, only individual Fund estimates were available as to the extent of these admissions. The last meeting of the SPGPPS discussed this matter and requested the SPGPPS Information Officer prepare material to present to the ISWG to enable it to develop a specification for exactly what questions need to be asked of the Hospitals Casemix Protocol (HCP), concerning psychiatric admissions to non–psychiatric private hospitals.

Mr Morris–Yates suggested that, in the absence of two key Australian Government representatives that this matter be deferred for in–depth discussion at the 38th Meeting of the SPGPPS. In the interim Mr Morris–Yates presented preliminary data from the Private Hospital's Establishment Collection 2001 – 2002, which gave the total activity in private hospitals for that financial year, but did not differentiate between psychiatric and non–psychiatric admissions. Using the data from the CDMS to gauge the amount of activity generated by private psychiatric facilities, it was possible to get an admittedly rough estimate of the number of separations of psychiatric admissions from non–psychiatric private hospitals**.** The analysis showed that a substantial proportion of such admissions are for conditions related to drug and alcohol problems. Mr Morris Yates proposed that Australian Government be asked to run an analysis of the most recent year's HCP data and stratify the data by facility location. This would answer the question of whether or not these admissions are predominately from regional and remote areas, with a dearth of private psychiatric facilities in that area.

Mr Morris–Yates reported that the data showed that less than 3% of patients with psychoses are admitted to non–psychiatric facilities. Only 2 % of patients comprised admissions with major affective disorders. Admissions rise sharply for patients with other affective disorders, particularly anxiety. Numbers of admissions of people with drug and alcohol disorders are generally very high. Ms Christine Gee suggested that one reason for this could be that a large number of alcohol and drug units are co–located in general hospitals.

Mr Morris–Yates reported that the ISWG had discussed this data with the view to ascertaining whether or not it would be of value to proceed further with an in–depth interrogation of the HCP data. Mr Morris–Yates indicated that the preliminary findings clearly suggest this approach is warranted.

Mr Morris–Yates then showed the results of an analysis he had undertaken on 2003 CDMS data, based on the patient rather than episodes of care. Mr Morris–Yates reported that the analysis showed that 23.7% of patients admitted had a principal or additional diagnosis of drug and alcohol use disorders. 14.8% had a primary diagnosis of drug and alcohol use disorders and 8.9% have that as a co–morbid diagnosis. Overall, 63.5% of all patients had one episode of care, 14.8% had two and 9.1% had three or more episodes of care. Only 12.7% had episodes of ambulatory care. This highlights the problems of over–counting when the unit of analysis is the episode of care. The data indicated that patients with a principal diagnosis of drug and alcohol use disorders are less likely to have multiple episodes of care and have a significantly reduced length of stay compared to other diagnostic groups. Mr Morris–Yates noted that on the self–report measure, patients with a principal diagnosis of substance abuse rate themselves significantly better at admission than do other groups, which is consistent with other findings.

Mr Morris–Yates reported that the proposed meeting with Department of Health and Ageing personnel concerning the correct coding for outreach services has been rescheduled. Initial feedback was that current coding consists of being admitted to in–patient care, discharged from in–patient care, admitted to outreach care and this is treated as one episode of care. There is a data element called *number of days spent at home,* which allows the number of days as an in–patient to be determined, but the occasions of outreach service are not coded for. Therefore, it is not possible to analyse the pattern of the interventions.

Mr Morris–Yates reported that this issue would be referred to the SPGPPS Substance Abuse and Dependency Working Group.

3.3 SPGPPS SUBSTANCE ABUSE AND DEPENDENCY WORKING GROUP (SDWG)

The Chair then asked the meeting to consider the self–explanatory draft report of the second SDWG Meeting, which had been circulated with the agenda and papers. In the absence of the SDWG Chair, Mr David Morton, the SPGPPS noted that SDWG had now largely completed the

task of informing the private sector on treatment guidelines for alcohol. The Alcohol Treatment Guidelines have been distributed to Hospitals participating in the CDMS and these Guidelines were further promoted by the SPGPPS through the SPGPPS Newsletter. SDWG is now undertaking a data gathering exercise and will then re–examine SDWG objectives including the need for outside expertise.

RESOLVED

That the Strategic Planning Group For Private Psychiatric Services (SPGPPS) notes the draft Report of the 2nd SPGPPS Substance Abuse and Dependency Working Group (SDWG), held on 4 August 2004.

4. DISCUSSION ITEMS

4.1 NAME CHANGE FOR THE SPGPPS

The Chair reported that the 36th SPGPPS Meeting considered a name change from SPGPPS to ***Private Mental Health Alliance***. Based on the ambivalent result of a straw poll at that meeting, Members and Observers were asked to consult their constituencies and report back to the 37th SPGPPS Meeting concerning whether a name change is necessary for the SPGPPS. At this meeting, the following stakeholder views were put forward

RANZCP is not unhappy about the name change and feels that Private Mental Health Alliance better reflects the work of the SPGPPS.

AMA supported the name change, but unless there was full consensus, felt the change was not justified.

Consumers and carer representatives supported a name change for reasons similar to RANZCP.

Health Funds did not support a name change because it had taken some time for SPGPPS to be reasonably established in the sector and a name change would engender confusion.

Hospitals did not support a name change, reasoning that even with a name change it would always be referred to as the former *spaghetti group*.

Australian Government did not support a name change but thought this should be the decision of the constituency.

RACGP did not support a name change

Following discussion the meeting unanimously agreed to the removal of the explanatory words from the top and bottom of the SPGPPS logo and the inclusion of the words Private Mental Health Alliance under the acronym SPGPPS. There was consensus that the acronym was now well known and the new wording under the logo represented a better explanation of what the SPGPPS had evolved to. The trademarked logo should stay the same but all future stationery should be arranged in this way.

The Secretariat was asked to prepare a draft of this arrangement to be considered at the next SPGPPS Meeting.

RESOLVED

That the Strategic Planning Group for Private Psychiatric Services (SPGPPS) requests the Secretariat to prepare a new SPGPPS logo for consideration at the next meeting of the SPGPPS.

4.2 ACCESS TO PSYCHIATRIC BEDS

The Chair reported that the 35th SPGPPS Meeting and Planning Day agreed that, in consolidating its current work program, the SPGPPS needed to debate the issue of access to psychiatric beds in the private sector for people with private health insurance, particularly for those people living in rural and remote areas of Australia, and those who have been detained against their will.

The 36th SPGPPS Meeting considered this issue and the Chair subsequently wrote to the appropriate State and Territory health authorities to ascertain their policies and legislation concerning certification of private Hospitals and what the barriers are to changing existing practices with regard to private hospitals being able to take involuntary patients. The meeting then considered the responses received from Queensland and Victoria, which had been circulated with the agenda and papers. The meeting agreed that the substantial Victorian document *Collaboration between Public and Private Sector Psychiatry*, though disappointing in terms of clear outcomes did serve as a framework for policy directions and was far in advance of other States' initiatives.

SPGPPS Hospital Representatives reported that they had raised the issue of private hospitals being able to take involuntary patients, with their State and Territory representatives. The Chair of the APHA Psychiatric Sub–Committee, Ms Gee reported that the difficulty with this issue is the difference in Mental Health Acts across the various States. Some States specifically exclude private hospitals from taking involuntary patients and others allow it under certain conditions. Queensland and South Australian 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. Ms Gee pointed out that there was also some confusion regarding regulated patients and forensic patients. Ms Gee advised that given the complexity of the situation, it would be necessary to look at all the States and Territory's Mental Health legislation.

The Chair of the National Network was concerned that this issue be progressed to enable private patients to be treated in the private sector. Dr Lammersma indicated that there were continuity of care issues to be considered. Ms Suzy Saw indicated that this issue should be referred back to AHMAC for consideration when they are reviewing their legislation, under the argument that disruption to continuity of care is a significant issue. It was agreed that this approach was the best way to progress this issue.

5 STANDING ITEMS

5.1 AHMAC NATIONAL MENTAL HEALTH WORKING GROUP

The Chair requested that the meeting note the draft report of the last meeting of the AHMAC National Mental Health Working Group (NMHWG) held on 2 July 2004 in Sydney, which had been circulated with the agenda and papers. In the absence of the SPGPPS representative on the NMHWG, Dr Yvonne White, the Chair invited the SPGPPS Observer on the NMHWG, Mr Phillip Taylor, to report on the NMHWG 2 July 2004 meeting. Mr Taylor reported that, as requested, Dr White had raised the issue of how the SPGPPS can work with the NMHWG to achieve better integration between the private and public sectors. In particular, the respective general policies and/or protocols of the States and Territories in relation to the following issues were discussed.

- Communication between the public sector and the private sector including general practice, particularly in relation to the provision of feedback from the public sector to the private sector after an episode of care.
- Utilisation of private sector beds when "bed overflow" occurs in the public sector.

At their request Dr White has written to the NMHWG Members concerning these issues and would continue to progress these issues.

Mr Taylor reported that the draft Implementation Plan for the National Mental Health Plan 2003–2008 is being re–drafted based on comments received. This was circulated to the SPGPPS and a number of SPGPPS stakeholders responded. The revised version will be considered at the next meeting of the NMHWG.

Mr Taylor reported that the discussion paper on *Workforce and Workplace Redesign* was circulated to the SPGPPS. The working group has agreed to hold a forum on the issue, which will be held in Canberra on Friday, 26 November, the same day as the 38th meeting of the SPGPPS. The working group has invited Dr White to attend that forum and the Secretariat had also lobbied for an invitation for an APHA representative to attend. Mr Taylor advised that he had sent an email to the working group Secretariat alerting them to the clash of dates with the SPGPPS Meeting. After discussion, it was agreed that the SPGPPS Meeting should remain as it is. SPGPPS representation at the forum will depend on the perceived importance of the forum to the work of the SPGPPS. Ms Saw indicated that the agenda was structured rather loosely and intended to be a forum for the presentation and gathering of ideas at this stage.

Mr Taylor reported that the next meeting of the NMHWG will be held on Friday, 5 November 2004 in Perth when he is on leave. It was noted that, in his absence, the SPGPPS Deputy Chair, Ms Moira Munro, will attend the NMHWG meeting as the SPGPPS Observer.

Mr Taylor then asked the SPGPPS representatives on NMHWG sub groups to report on their meetings. The Chair reported that the major outcome from the NMHWG Information Strategy Committee (ISC) was an invitation to the SPGPPS to sit on the working group developing the Key Performance Indicators.

Ms Janne McMahon queried progress with the National Disasters and Terrorism Working Group. Mr Taylor and Ms Saw explained that this initiative involved bringing together widely diverse sectors. It is anticipated that this will be a substantial item on the agenda for the next meeting of the NMHWG. Dr Pring related that each State has its own disaster plan and each fits into an overarching Commonwealth disaster plan. The NMHWG National Disasters and Terrorism Working Group ties into the Commonwealth plan.

5.2 CONSUMERS AND CARERS REPORT

The Chair invited the SPGPPS Consumer Representative, Ms Janne McMahon and Carer Representative, Mrs Ruth Carson, to report on any current issues relevant to consumers and carers. Ms McMahon reported that the 8th Meeting and Planning Day of the National Network for Private Psychiatric Sector Consumers and Carers (National Network) was held on 23 and 24 August 2004 at RANZCP Headquarters in Melbourne. Ms McMahon reported that the major outcome of the two days of meetings was agreement on the following Strategic Objectives for the National Network over the next two years.

1 *Strengthen consumer and carer representation and participation in private hospital–based settings.*

2. *Strengthen the functioning of National Network State and Territory–based committees.*

3 *Strengthen and recognise the role of carers .*

4 *Strengthen the National Network relationships with key stakeholders.*

5 *Raise the profile of the National Network.*

6 *Raise awareness of mechanisms for the handling of complaints in private sector mental health services*

7 Secure ongoing funding beyond 2006 for the National Network

Ms McMahon reported that the Strategic Plan would be circulated to the SPGPPS and National Network stakeholders shortly.

Ms McMahon reported that the National Network conducted a thumbnail sketch into awareness by consumers and carers of complaints mechanisms in private hospitals. This will be presented at the next meeting of the APHA Psychiatric Sub–committee.

Ms McMahon reported that she had been invited to attend meetings of the APHA Psychiatric Sub–Committee as an Observer, which is a very useful linkage for the Network. Ms McMahon will also attend the next meeting of the AHIA Mental Health Committee. Ms McMahon reported that Mr Harry Lovelock, the new Director of Policy for the RANZCP has requested that he be able to attend National Network Meetings as an observer.

Dr Lammersma suggested that Mr Lovelock be invited to attend the next meeting of the SPGPPS as an observer.

The National Network also asked that the SPGPPS undertake to ensure that the PBS is protected. Dr Nothling reported that the AMA's Therapeutics Committee had been lobbying extensively to preserve the integrity of the PBS and maintaining the present price structure. Ms McMahon indicated that the National Network intends to write to the major political parties before the next election outlining the major role the private sector has in providing mental health services and emphasising the concerns that the Network has over any changes to the PBS, given that the most common therapeutic intervention in mental health is medication. Dr Nothling suggested that the Network insist in the letter that the Pharmaceutical Benefits Advisory Committee (PBAC) process should become transparent. PBAC should be able to publish their decisions regarding the efficacy of newer medications compared to older medications, rather than being bound as they are currently by commercial in–confidence regulations.

Dr Lammersma reported that patients with mood disorders do not have access to the anti–psychotic medication made available only to schizophrenics, where evidence–based practice indicates that these medications in low doses can be of great benefit to other diagnoses. The most powerful lobby for better access to appropriate medication is consumers and carers. Ms McMahon reported that this issue would also be raised in the pre–election letter to the political parties. Ms Saw suggested that Ms McMahon forward her presentation on consumer and carer preferences in models of care in hospital–based settings to the AHMAC NMHWG to offer that group a consumer and carer perspective when planning the *Workforce and Workplace Redesign* forum.

5.3 HOSPITALS REPORT

Ms Christine Gee reported that the APHA hopes that the CDMS forum held in Queensland to promote better understanding and utilization of data from the CDMS, will be taken up by the other States.

The Chair and Ms Gee reported that a representative of the ACHS attended and addressed the last meeting of the APHA Psychiatric Sub–committee concerning the ongoing arguments between Hospitals and ACHS and what progress had been made. Ms Gee reported that a letter from ACHS to the Australian Government concerning funding, though long delayed, had finally been sent. There are now more consumer surveyors qualified to undertake surveys in the private sector.

Ms Gee reported that more Hospitals are seeking accreditation against the National Standards for Mental Health Services (NSMHS). There is a level of frustration with ACHS concerning the on–going issues of extra costs (double) to Hospitals of accreditation against the NSMHS. ACHS

for its part feels that this is not their problem and that there is a need for more direction from the Government. The APHA intends to follow this issue on a monthly basis.

Ms Saw reported that a National Standards Implementation Working Group is to be re–convened under the NMHWG Safety and Quality Partnership Group (SQP).

Ms Gee reported that the APHA Psychiatric Sub–committee was working to establish some nationally consistent framework around leave policy, borne out of the vulnerability Hospitals had identified with patients going on leave and the responsibility and safety issues surrounding that.

The Chair asked the RANZCP if the issue of leave had been looked at by the College. Dr Lammersma said the issue had not arisen, but if the APHA Psychiatric Sub–committee was seeking comment the person to contact is Dr Nigel Pryor, Chair of the RANZCP Board of Practice Standards Committee.

5.4 PSYCHIATRISTS REPORT

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

RANZCP Clinical Practice Guidelines (CPGs)

Dr Lammersma reported that the consumer and carer version of the RANZCP Clinical Practice Guidelines (CPGs) are now available on the public section of the RANZCP website and in booklet form. Mr Morris–Yates asked if these documents could be distributed to Hospitals electronically as part of their Quarterly Reports as is done with other useful documents. Dr Lammerma did not think this was a problem as the CPGs were a government–funded project. Mr Taylor reported that the solution the SPGPPS had found to referencing documents on its website was to provide a link to the publication site.

Psychiatric Workforce

Dr Lammersma reported that the survey data on the psychiatric workforce is currently being analysed and Dr Lammersma tabled copies of the presentation prepared by Professor Phillip Boyce, which uses information from the survey as well as other sources. The College intends to do annual surveys and is currently devising the questions to be included. Mr Harry Lovelock is supervising this process. Dr Lammersma advised that if the SPGPPS had specific questions about the psychiatrist work force they wanted answers to, they could pose these to the College.

New MBS Items

The new MBS Items are progressing well, but due to the Federal election and the Government being in caretaker mode these new items will not be included in the MBS until next year. Associated with the MBS items, Mr Lovelock and Dr Lammersma are currently developing a GP–Psychiatrist liaison policy. The developed policy will include proformas for GP referrals and proformas for management plans sent back to GPs, as well as information on the concept of shared care and educative materials about the changes brought about by the new MBS items. Dr Lammersma advised that the policy documents could be made available to the SPGPPS by November 2004.

Medical Reports to Health Funds

The meeting then considered the correspondence received from the RANZCP, concerning medical reports to Health Funds for extensions of funding for Day Programs, circulated with the agenda and papers for this meeting. Dr Lammersma indicated that there is a need to balance the requirements of Health Funds for necessary information with protecting the privacy of the patient. Dr Nothling was concerned that clinical information should only go to those in a position to properly assess it

such as clinical advisors retained by Health Funds. Health Fund representatives indicated that there is no prescriptive answer to requests for what amounts to extra funding, as this depends on the Health Fund concerned and the case. Following discussion, it was agreed that Health Fund representatives would report back to the next meeting on what Health Fund base such requests for information on.

RESOLVED

That the Strategic Planning Group for Private Psychiatric Services (SPGPPS) requests its Health Fund Representatives to report back to the 38th Meeting of the SPGPPS as to what Health Fund requests for medical reports are based on.

Mother and Baby Admissions

In relation to the issue of a mother admitted for psychiatric treatment, and Health Funds refusing to pay benefits for the baby, at the last meeting of the SPGPPS, Mr Brian Osborne undertook to contact the Health Fund concerned. A letter from MBF responding to this issue was circulated with the agenda and papers for this meeting. Dr Lammersma reported that the RANZCP was in the process of establishing a working group on post–natal psychiatry to develop RANZCP guidelines for best clinical practice on this issue. The meeting agreed that Consumer and Carer, Health Fund, Hospital input into this process was important to ensure this important issue was properly resolved. Dr Lammersma agreed to discuss this with the RANZCP with a view to these stakeholders being invited to participate in the RANZCP process.

RESOLVED

That the Strategic Planning Group for Private Psychiatric Services (SPGPPS) requests that its Royal Australian and New Zealand College of Psychiatrist's Representative, Dr Jo Lammersma, discuss with the RANZCP, involvement of Consumer and Carer, Health Funds and Hospitals Representatives with the RANZCP Working Group on post–natal psychiatry.

Electro–convulsive Therapy (ECT)

Since the last meeting of the SPGPPS, correspondence from the RANZCP was received concerning ECT. A copy of the exchange of correspondence between the Chair of the RANZCP Committee for Psychotropic Drugs and Other Physical Treatments and the Chair of the SPGPPS, which was circulated with the agenda and papers was then discussed. The meeting noted that two Health Funds are persisting in rebating only 12 treatments per year (for hospital fees). The other major funds now have no limit. Mr Brian Osborne agreed to follow–up with these two Health Funds.

RESOLVED

That the Strategic Planning Group for Private Psychiatric Services (SPGPPS) requests that its Health Funds Representative, Mr Brian Osborne, follow–up with the two health funds that rebate only 12 ECT treatments per year, when all other major health funds have no limit.

5.5 GENERAL PRACTITIONERS REPORT

The Chair invited the RACGP representative, Dr Brian Kable, to report on any current issues relevant to general practitioners, that requires consideration or action by the SPGPPS. Dr Kable reported that the Mental Health Collaboration had been funded for another year. The standards have been reviewed and promulgated as required. As the program is now well established, the Collaboration is now looking at gaps in service provision and in educational areas such as co–morbidity or youth or aged.

The Better Outcomes in Mental Health Care Initiative (BOIMHC) is a lapsing program, which runs out after this budget round. The constituent bodies involved have applied to the Minister for Health to have the BOIMHC continue as a policy rather than an initiative. Communication is seen as a priority to advertise that there are GPs who have done advanced training and that urgent psychiatric advice is available through a 1800 number or email anywhere in Australia. A position statement advertising the Initiative is currently being drafted.

Dr Kable reported that 3700 GPs are registered under Level 1 and 700 GPs are registered under Level 2 training. It has been established that on average a patient has a 1 in 4 chance of visiting any practice and finding a GP registered under Level 1 of the initiative. For larger practices of more than 6 doctors, this rises to 60%.

Demand for the Initiative is strong among GPs but there seems to be a lag in uptake of the MBS items, possibly because GPs are concerned about stigma affecting their patients.

Ms Saw indicated that the evaluation of the BOIMHC is underway at the moment.

HEALTH FUND REPORT

The Chair invited the Health Fund Representatives, Mrs Judy Hardy and Mr Brian Osborne to report on any current issues relevant to Health Funds that requires consideration or action by the SPGPPS.

The AHIA Mental Health Committee (MHC) set itself some goals to set some standard of accountability and Mr Osborne reported that he had been able to write to the AHIA reporting substantial progress with those goals. The MHC is currently developing some new goals including to pursue the ability to compare substance abuse programs. and inform their members of the programs most suited to their needs. The current goals of the MHC are appended to this report as Appendix 1.

Mr Osborne thanked the other SPGPPS stakeholders for their appreciation of the complex and difficult funding issues facing Health Funds. Mr Osborne raised the issue of protheses as an example of the technologies that may become available in Australia and the costs involved with such technologies. The figures are that the unbudgeted cost of prostheses will be $ 100 million this year alone. There are also rising costs to Health funds associated with aged care and a number of other areas. Resources are limited and will only become more restricted. Health Funds are seeking to keep costs down. Hospitals need to remain viable. Health Funds cannot have a product, which is too expensive for members to afford and Governments currently frown on premium increases. These are some of the drivers in funding issues. Mr Osborne indicated that a new pressure on existing resources may come from psychiatric prostheses, the implantation of electrodes as an aid in treating, for example, Parkinson's Disease or depression. These procedures are very expensive.

The Chair indicated that the concern of the SPGPPS is that rising costs, which are a legitimate concern for Health Funds should not be curbed by unfairly targeting the psychiatric sector. Mrs Hardy felt the SPGPPS should consider the increase in the number of psychiatric beds being established that is occurring across Australia.

Dr Pring indicated that it would be useful to have firm trend data on whether or not psychiatric beds were increasing and whether costs in psychiatry were increasing in parallel with other health fields.

5.5 AUSTRALIAN GOVERNMENT REPORT

Ms Suzy Saw reported that the Australian Government had no further issues to raise.

6. NEXT MEETING

The next meeting of the SPGPPS will be held on Friday, 26 November 2004 at AMA House, 42 Macquarie Street Barton in Canberra ACT. The meeting will commence at 9:00 AM and conclude at 4:00 PM. It was agreed that an SPGPPS *End of Year Dinner* should be held on the evening of Thursday, 26 November 2004. Mr Taylor reported that he would be on leave form 23 September until 9 November 2004 inclusive. During that time, all urgent matters should be referred to the SPGPPS Administrative Officer, Ms Bronwen van der Wal. Ms van der Wal, where necessary, will discuss such matters with the SPGPPS Chair and relevant members of the SPGPPS and then take appropriate action. Mr Taylor sought the support of the SPGPPS for Bronwen during his absence.

7. CLOSE

There being no further business, the Meeting closed at 4:30 PM. In doing so the meeting thanked Ms Munro and the staff of the Perth Clinic for hosting the 37th SPGPPS Meeting and 9th ISWG Meeting.

Ms Moira Munro
Chair

Mr Phillip Taylor
Secretary