STRATEGIC PLANNING GROUP FOR

SPGPPS

PRIVATE PSYCHIATRIC SERVICES

THIRTY SIXTH MEETING

HELD AT
NEW FARM CLINIC
22 SARGENT STREET
NEWFARM QLD
ON
FRIDAY, 11 JUNE 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
DHA	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–Sixth (36th) Meeting of the SPGPPS was held on Friday, 11 June 2004 at the New Farm Clinic in Brisbane.

1. PROCEDURAL MATTERS

1.1 OPENING/WELCOME/APOLOGIES/PROXIES/GUESTS

The Chair of the SPGPPS, 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 Chris Keegan	(proxy for Ms Sharon Brownie)

Australian Medical Association (AMA)

4.	Dr Martin Nothling	
5.	Dr Bill Pring	(Observer)

Australian Government (AG)

6.	Mr Peter Callanan	Department of Health and Ageing, Private Health Insurance
7.	Ms Katherine Bates	Department of Health and Ageing, Private Health Insurance
8.	Ms Suzy Saw	Department of Health and Ageing, Health Priorities & Suicide Prevention

Consumer Representative

9.	Ms Janne McMahon	National Network of Private Psychiatric Sector Consumers and Carers (Chair)

Royal Australian College of General Practitioners (RACGP)

10.	Dr Brian Kable	

Private Hospitals with Psychiatric Beds (Hospitals)

11.	Ms Moira Munro	SPGPPS Deputy Chair
12.	Ms Sue Williams	

Private Health Insurers (Health Funds)

13.	Mrs Judy Hardy	
14.	Mr Brian Osborne	

SPGPPS Secretariat

15.	Mr Phillip Taylor	SPGPPS Executive Officer
16.	Mr Allen Morris–Yates	SPGPPS Principal Information Officer

Invited Guests

19.	Ms Fiona Shand	Project Officer, National Drug and Alcohol Research Centre (NDARC)
20.	M Sue Feeney	CEO, New Farm Clinic

1.2 APOLOGIES

1.	Ms Sharon Brownie	Royal Australian and New Zealand College of Psychiatrists
2.	Mr David Morton	Department of Veterans' Affairs (DVA)
3.	Ms Ruth Carson	SPGPPS Carer Representative

1.3. REPORT OF THE 35TH MEETING AND PLANNING DAY OF THE SPGPPS

The meeting approved the draft report of the 35th Meeting and Planning Day of the SPGPPS held on 12 March 2004 in Sydney.

RESOLVED (Unanimous)

1. *That the SPGPPS approves, as a true and accurate record, the report of the 35th Meeting and Planning Day of the SPGPPS held on 12 March 2004 in Sydney.*
2. *That the SPGPPS directs that the Report of the 35th Meeting and Planning Day of the SPGPPS be made available on the SPGPPS website at: www. spgpps.com.*

1.4. PROGRESS REPORT ON ACTIONS ARISING FROM THE 35TH MEETING AND PLANNING DAY AND OUT– OF–SESSION DECISIONS

The SPGPPS noted and updated the following Progress Report on Actions Arising from the 35th Meeting and Planning Day of the SPGPPS and discussed any out–of–session decisions.

	Agenda Items	ACTION OFFICER(S)	STATUS
	Report on the 35th SPGPPS Meeting & Planning Day		
➢	Draft and circulate report of 35th Meeting & Planning Day for comment	Secretariat	Done
➢	Revise Report based on comments received & prepare final	Secretariat	Done
➢	Agenda Item 36th SPGPPS Meeting	Secretariat	Done
2	Report on the 34th Meeting of the SPGPPS		
➢	Post Report on the SPGPPS website	Secretariat	Done
3	Progress Report on Actions Arising 34th Meeting and Out– of–Session Decisions		
➢	Letter to ACHS on progress with agreements reached at 17 Nov 2003 Meeting	Secretariat/Hospitals/Chair	Done
➢	Revise SPGPPS Operating Guidelines & Agenda Item 36th Meeting	Legal Counsel/Secretariat	Done
➢	Arrange FC Meeting for end 1st ¼ 2004 & Agenda Item 36th SPGPPS Meeting	Secretariat	Done
➢	National Network Agenda Item 36th SPGPPS Meeting under Consumers & Carers	Secretariat	Done
➢	Revise Privacy Kit with OFPC and prepare and circulate final in PDF format	Ms Burton/Dr Pring/Mr Taylor	Done
➢	Substance Abuse and Dependency (SDWG) Agenda Item 36th SPGPPS Meeting	Secretariat	Done
➢	Obtain and circulate the NDARC schedule of Guidelines Workshops	Secretariat	Done
➢	Construct profile of current practices from CDMS	Mr Morris–Yates/SDWG	*Pending*
➢	Convene 1st and 2nd ISWG meetings for 2004	Secretariat/Dr Pring	Done
➢	Organise face–to–face of ISWG for Thursday, 10 June 2004	Secretariat	Done
➢	ISWG refer issue of psychiatric admissions from non–psychiatric private hospitals to SPGPPS	Mr Osborne/Secretariat	Done
➢	ISWG Agenda Item for 36th SPGPPS Meeting	Secretariat	Done
➢	AG To circulate the Guidelines for Determining Benefits	AG	Done
4.1	SPGPPS Draft Annual Progress Report		
➢	Circulate Progress Report to the Parties to the AMA Agreement for Services 2004–2006	Secretariat	Done
➢	Post Progress Report on SPGPPS Website	Secretariat	Done
5	AHMAC National Mental Health Working Group (NMHWG) Report		
Item 6	Circulate S&Q National Action Plan to SPGPPS	Secretariat	Done
Item 6	Dr White to attend Safety and Quality Partnership Group Meeting Sydney 26 March 2004	Dr White	Done
Item 15	Circulate copy of Item 15 on the International Institute of Mental Health Leaders	Secretariat	Done
Item 18.2	Agenda Item 37th SPGPPS meeting on mental illness & obtaining insurance	SPGPPS	*Pending*
➢	Agenda Item 36th SPGPPS Meeting	Secretariat	Done
6.1	Priorities for 2004 –2006 and Work Program		
1	Review IMWG Terms of Reference	SPGPPS	*Pending*
2	Re–develop SPGPPS website	Secretariat	*Commenced*
2	Use CDMS & Other Data to demonstrate what SPGPPS is doing	CDMS/SPGPPS	*Pending*
2	Consider name change for SPGPPS	SPGPPS	*Pending*
3	Explore Barriers to better integration between private & public sectors	SPGPPS	*Pending*
4	Prepare paper on co–morbidity	Dr Pring	*Pending*
5	Continue to participate in existing structure dealing with Safety & Quality	SPGPPS	Done
6	Consider issue of access to psychiatric beds for people with private health insurance	SPGPPG	*Pending*
7	Establish linkages with appropriate groups	SPGPPS	*Pending*
7	Next Meeting		
	Organise "Dial–in" EO teleconference for 6 April 2004 at 7:30 PM	Secretariat	Done
	Organise 36th SPGPPS Meeting New Farm Clinic Brisbane	Secretariat	Done
	Organise SPGPPS Dinner 10 June in Brisbane	Secretariat	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 33rd Meeting of the SPGPPS directed that an SPGPPS Finance Committee be established to meet and monitor budgetary expenditure, on a quarterly basis, for all present and future SPGPPS activity. It was noted that the Committee is currently constituted as follows.

1.	AMA	Dr Martin Nothling (Chair)
2.	RANZCP	Dr Jo Lammersma
3.	Australian Government	Ms Suzy Saw
4.	Hospitals	Ms Sue Williams
5.	Health Funds	Mr Brian Osborne
6.	AMA Corporate Services	Mr Howard Pickrell
7.	National Network	Ms Janne McMahon
8.	CDMS	Mr Allen Morris–Yates
9.	SPGPPS Secretariat	Mr Phillip Taylor (Secretary)

The Chair of the Finance Committee, Dr Martin Nothling, reported that the second meeting of the Committee was held on 29 April 2004 via teleconference. The SPGPPS noted that the Committee has endorsed the reporting format developed by the AMA for the Statements of Income and Expenditure for the SPGPPS, its CDMS and the National Network. The Committee is satisfied that the spending pattern for the first quarter of 2004 for SPGPPS, CDMS and the National Network is appropriate and within budget. The Committee has asked the AMA to roll the CDMS overspend of $22,943, as quarantined at 31 December 2003, into the CDMS accounts at 31 December 2004 and advise of any remaining overspend at that time. The AMA anticipates the overspend will be greatly reduced by that time to the order of $5000 to $6000, after the SPGPPS Information Officer takes his accumulated annual leave in 2004.

Dr Jo Lammersma notified the meeting that the College had decided that Mr Chris Keegan would replace her as the RANZCP representative on the SPGPPS Finance Committee.

RESOLVED (Unanimously)

1. *That the SPGPPS approves and adopts the Draft Report of the Second Meeting of the SPGPPS Finance Committee held on 29 April 2004.*
2. *That the SPGPPS notes that Mr Chris Keegan will replace Dr Jo Lammersma as the Royal Australian and New Zealand College of Psychiatrist's representative on the SPGPPS Finance Committee.*

2.2 SPGPPS OPERATING GUIDELINES

The Chair reported that the SPGPPS Legal Counsel, Ms Jane Ferry, had undertaken a comprehensive review of the *SPGPPS Operating Guidelines* (hereafter Guidelines) to better reflect the responsibilities of the SPGPPS under the overarching *AMA Agreement for Services 2004–2006*, which came into effect on 1 January 2004.

The Chair advised that the current Guidelines can only be repealed or amended by resolution of three quarters of Representative Members of the SPGPPS voting, in person or by proxy, at a meeting of the SPGPPS. Not less than 21 days written notice must be given to all members of the SPGPPS of the proposed repeal or amendment(s).

Mr Taylor explained that minor amendments were made to the preamble to the Guidelines to better reflect the current role of the SPGPPS. Additional acronyms were included, the National

Network, for example. Mr Taylor indicated that SPGPPS Members and Observers should consult with their stakeholders and advise the Secretariat of further necessary amendments and/or additions.

Ms Judy Hardy requested that the acronym for the Australian Health Insurance Association, AHIA, be added to clause *3. Interpretation of the Operating Guidelines*. Ms Janne McMahon requested the Guidelines on consumer and carer representation (clauses 8.4.10 and 8.4.11) be amended to read *one carer being nominated by the National Network to represent carers and one consumer being nominated by the National Network to represent consumers*.

RESOLVED

1. *That the SPGPPS notes the revised draft version of the SPGPPS Operating Guidelines, prepared by the SPGPPS Legal Counsel, Ms Jane Ferry, and requests that the draft version be amended in accordance with the recommendations arising from the 36th Meeting of the SPGPPS.*
2. *That the SPGPPS requests that the SPGPPS Executive Officer issue a 21 day written notice to all Representative Members of the SPGPPS of the intention to repeal the current SPGPPS Operating Guidelines at the 37th meeting of the SPGPPS to be held on 10 September 2004.*

3. WORKING GROUP REPORTS

3.1 SPGPPS INNOVATIVE MODELS WORKING GROUP (IMWG)

The Chair reported that, in 2003, the SPGPPS established the IMWG to encourage the uptake of innovative models of service delivery and enhance co–ordination of care between general practitioners, psychiatrists and hospitals.

The SPGPPS noted that prior to the 2003 Christmas/New Year holiday break, the IMWG was gathering information concerning the barriers to the uptake of Outreach Services for Hospitals. To that end, Mr Peter Callanan had provided the current list of Hospitals with Approved Outreach Services to the SPGPPS Secretariat. The Secretariat provided both the list and the contact details of Hospitals without these services to Ms Sue Williams. Ms Williams agreed to go back to the Hospital State representatives for them to ascertain what current barriers there may be to the uptake of Outreach Services by these Hospitals. Ms Williams reported that the key obstacles to uptake of outreach services for Hospitals include:

- inability to achieve economies of scale, particularly at sites that have a geographically dispersed catchment area; and
- reluctance by some Health Funds to fund outreach services.

Ms Williams reported that nearly every Hospital in Victoria has now taken up outreach services.

3.1.1 HEALTH FUND PRESENTATION ON INNOVATIVE MODELS OF CARE

The Chair invited Mr Brian Osborne to address the meeting on innovative models of care in the private sector.

Mr Osborne related that the AHIA Mental Health Committee held a *Funding Models Workshop* in November 2003, at which a number of different approaches to the funding of mental health services by various health funds were presented. Mr Osborne pointed to the catalysts for change in the funding of mental health services.

In 2002 – 2003, membership of health funds fell by just under 0.5%. At the same time, the average age of Health Fund members was increasing at a rate of 0.2 years per annum. Payments made by health funds had increased from 2002 to 2003 by 5.2%. During the same period, the

number of private psychiatric beds in Australia increased by about 230 and are still increasing. Health Funds see private psychiatric services, as a high cost area for its size and sometimes Health Funds decline to provide funding for programs for the following reasons.

- Health Funds are traditionally wary of new programs that represent an additional cost on top of an already high–cost area.
- It is very difficult to objectively assess the effectiveness of a program among the range of treatments and modes of treatment offered.
- It is necessary to ensure, beforehand, that a new program is a true substitute for services and that it will facilitate a more appropriate service. This is a difficult task, which can be achieved through funding arrangements based upon the following principles.
  - Profit sharing – a sharing of costs and benefits.
  - A range of suitable cost–effective services available to substitute for overnight admission where appropriate.
  - Delivery to the Health Fund member of the appropriate treatment in the appropriate setting.
  - Appropriate utilisation. In an environment where providers are paid on a set per diem basis, one way to improve revenue is to increase quantity of throughput.

Mr Osborne then described some of the approaches demonstrated at the *Funding Models Workshop*.

Program–based Payment Model

This is currently in the planning stage. There is a perception that the current system of per diem and step–down funding arrangements has been relatively ineffective in moving away from a focus on in–patient care to out–of–hospital type services. Even where Health Funds have supported day programs or other alternative services, there still has not been a significant shift of patients to these programs. A Program–based Payment system is seen as an appropriate cost neutral platform from which to introduce subtle changes and further changes within the system. These programs involve several levels

Global Level

- A total Health Fund analysis of all Mental Health Programs (as defined by the Fund).
- Determine benefits paid per program (including all services).
- Determine average length of stay (ALOS) per program (compared to Clinical Practice Guidelines where available).

Individual Provider Level

- Total benefits per Program (all services).
- Average per diem benefit paid.
- ALOS per Program.
- Calculate Program–based Payment, based on Hospital ALOS per Program.
- Follow–up discussions with the facility with regard to movement from Hospital ALOS to ALOS supported by Clinical Practice Guidelines, where available.

The Program–based Payment model aims to provide a total profile for Health Funds of funded psychiatric services, highlighting benefit distribution patterns and ALOS indicators, and to

demonstrate the application of the principles of the proposed funding Model (and anticipated effect) through a cost benefit analysis.

The advantages of this model are that it is a simplified alternative method of funding that is relatively low risk to all parties. It shifts the focus from revenue to standards of clinical practice and is an opportunity for further discussion and funding options.

Dr Lammersma indicated that this system, as it is worked out on the average and not on the individual, would disadvantage individual patients and would not take into account the severity of the illness, or the fact that many patients have co–morbidities. Mr Osborne indicated that all negotiation between Hospitals and Health Funds depends to some extent on the average of several indicators. Dr White reported that the model puts pressure on Hospitals where decisions on treatment are made by the treating psychiatrist. Ms Janne McMahon referred to Health Fund practices of capping, in dollar value or number of days access to, day programs. Mr Osborne pointed out that this was a perverse effect of the per diem model of funding, and other models were necessary to increase flexibility in the system.

The Prospective Payment Model

Mr Osborne reported that the Prospective Payment Model was used in the South Australia Model four years ago. At that time, AXA/BUPA was providing 90% of benefits to the three psychiatric hospitals of the single provider in that State. Bed numbers were stable, membership had fallen slightly, but costs for psychiatric care were rising by 8–9% per annum. The Hospitals were almost totally reliant on funding for in–patient services, with very little incentive to establish substitutes for in–patient care. Under the Prospective Payment Model, the provider was paid an agreed annual figure spread over 12 monthly payments of equal value within each year, thus ensuring a regular known income.

Advantages

The Model was designed as a change to funding only, at the highest level, from retrospective to prospective, as such it does not interfere with clinical decision making and creates greater choice of alternative services available to both consumers and clinicians.

Outcomes

Since inception of the Model, there have been the following changes in the provider's service profile in South Australia.

- 36% reduction in total in–patient beds required.
- Opening of a full time community service at Fullarton Day Hospital (May 2002), and subsequent transfer of all Programs to Kahlyn Day Hospital from October 2003.
- Opening of a Day ("Bridges") Program at The Adelaide Clinic for elderly program patients.
- A statistically significant increase, particularly in community (outreach) visits from both the Adelaide Clinic and Fullarton Hospitals.
- Out–patient–based assessments for patients attending elderly services.
- Introduction of pre–admission assessment for other programs.
- Family counseling service.
- Telephone–based patient counseling service.
- Trial of a multidisciplinary Intensive Assessment and Treatment service with links to the Community.

Every year since the inception of the Model, the number of in–patients episodes has fallen and the number of non in–patient episodes has increased. Increasing costs have been contained and there is funding of a better mix of services. Mr Osborne reported that trends indicate that patients who were previously admitted patients before the establishment of the model tended to be treated on an in–patient basis, albeit with more outreach programs. The data, however, shows that in the last 18 months, newer patients tend to be treated as out–patients or very short–term in–patients.

Ms Sue Williams indicated that there are risks with the wider application of this Model. South Australia has no competition, management of doctors and the length of stay are problematic, and there is discounting of future funding levels. Mr Osborne explained that funding levels would not be decreased because in–patient episodes have been reduced. The negotiations with Hospitals would encompass the total benefits paid, or it would be expressed as benefit per member covered. Dr Lammersma reported that the influences on clinical management were subtle and functioned as raising awareness of alternatives rather than direct marketing of alternative treatment modalities. Ms McMahon reported that the Outreach service in South Australia is working very well and is keeping people out of hospital. Mr Osborne indicated that in his opinion, applying this model in States with multiple competitors, was feasible, but the methods are yet to be worked out.

Evaluation

Mr Osborne explained that this Model was subject to two evaluations, conducted with the participation of the Australian Government by Professor Robert Goldney, Associate Professor of Psychiatry at Adelaide University. The evaluation found that there were no significant changes in the following.

- Transfers to other Hospitals
- Re–admission rates
- Adverse Events
- Inpatient LOS
- Access to services

Examination of HoNOS and self–reported measures found no negative impact on in–patient related quality of life scores. Evaluation showed no change in staff or patient satisfaction, based on surveys of Hospitals.

Conclusion

Mr Osborne noted that the evaluation report of minor fluctuations in psychiatrist's satisfaction with in–patient services, referred to admission procedures and the reception department. Patient reservations about day patient services reflected the finding that existing patients wanted to remain with in–patient services. Mr Osborne concluded that this reflected that the process is about education and culture change, which will take time.

Dr White commented that day programs also involve transportation to and from the facility, which can be a major obstacle for some patients. Day programs must also be attached to the facility and this prevents facilities from establishing programs in more easily accessible locations in the suburbs. Patients also report that they prefer treatment as in–patients because part of their problem is coping with the challenges at home. Ms McMahon indicated that the consumer does not choose the treatment modality, their treating psychiatrist makes that decision.

The Case Management Model

The Case Management model was developed in relation to the management of patients with chronic health problems. Mr Osborne reported that two Health Funds in Victoria are trialling an initiative with a group of independent clinicians in the general medical area to assist and support the GP or specialist in the management of the Health Fund member's health. The group organizing the service is composed of emergency physicians, GPs and nurses. The service includes,

- a comprehensive medical assessment;
- drafting of an individual Care Plan, where necessary;
- organising reviews, appointments, home visits, medication compliance etc;
- 24 hour telephone support;
- pro–active calls to remind patients to take their medication and note any problems;
- response to problems arising before these become serious;
- updating of the Care Plan with every event, which the patient has a copy of; and
- electronic Care Plan available to GP, hospital etc as an updated and shared medical record.

Criteria

- Member, GP, Specialist consent.
- Previous admissions for one or more common chronic conditions (respiratory, cardiac, diabetes, arthritis), *or*
- Medical Presentation symptomatic of a common chronic illness, eg: IHD, definition of COAD, evidence of asthma, emphysema (CO diffusion capacity etc), Rheumatoid Arthritis (ESR, RF^+ or Hb results), *or*
- High risk of further hospitalisation, *or*
- Factors such as social isolation, dementia, age etc, *or*
- Degree of clinical, carer and home support.

Mr Osborne reported that BUPA has over a hundred of its health fund members on this care plan and the members and their GPs are happy with this system. Mr Osborne suggested that similar arrangements could be put in place for chronic mental health conditions.

The Chair thanked Mr Osborne for his presentation.

3.1.2 REVIEW OF THE IMWG TERMS OF REFERENCE

The Chair reported that, the 35th SPGPPS Meeting and Planning Day agreed to review the IMWG's terms of reference to ensure it has the capacity to properly explore the funding models for service delivery that exists, and to continue to address the barriers to their uptake in the private sector. The SPGPPS agreed that this should be done following the Health Fund presentation on innovative models at this meeting of the SPGPPS. The SPGPPS then noted that the original Terms of Reference for the IMWG were as follows.

1. *Review what work has already 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. *Agree on what other innovation in models of service delivery can be envisaged.*

3. *Consider the obstacles to achieving innovation in service delivery and determine a set of practical recommendations for consideration and endorsement by the SPGPPS.*

Mr Osborne indicated that there are three ways to progress innovative models of service delivery. The first is through the SPGPPS Information Strategy Working Group, looking at appropriate measures to evaluate new models of service. The second is through the National Network providing feedback on what types of service they need, or would like to see available. The third is through the IMWG looking at the outcomes of the models discussed today, or other models that have demonstrated potential to make a change for the better, and encouraging the uptake of these models.

After discussion, it was agreed that the second term of reference should be amended to read:

2. *Agree on what other funding arrangements that give rise to innovative models of service delivery can be envisaged.*

It was further agreed that a preamble was needed to reflect the expectation that the working group would focus on consideration of the merits or otherwise of models of service delivery rather than deliver distinct recommendations that need to be enforced. The amendments would be discussed at the next teleconference of the SPGPPS. The need for the Chair of the IMWG to be as independent of stakeholder interests as possible was also considered. Following discussion, it was agreed that, while the membership of the IMWG should remain the same, the SPGPPS Executive Officer should Chair the Group. Mr Taylor accepted the role.

Ms Williams suggested that the stakeholder groups represented on the SPGPPS should present from their perspective on innovative methods of service delivery. It was agreed that the Hospitals and Consumers and Carers would present their viewpoints at the 37th SPGPPS Meeting to be held on September 10 2004 in Perth. Given the meeting time constraints, it was agreed that copies of the presentation should be included in the agenda papers for 37th Meeting.

Mr Taylor informed the meeting that Mr David Morton was a late apology for the meeting and that in his absence Members and Observers were advised to read the Consultation Paper titled *Improving access to community based mental health care options for veterans* and forward comments directly to Mr Morton. Mr Morton can be contacted by phone on 02 6289 6601 or by email to david.morton@dva.gov.au.

RESOLVED

1. *That the SPGPPS requests that the SPGPPS Secretariat prepare a revised version of the Terms of Reference for the SPGPPS Innovative Models Working Group, based on the recommendations of the 36th SPGPPS Meeting, for consideration at the 20 July 2004 SPGPPS Executive Officers Teleconference.*

2. *That the SPGPPS appoints the Executive Officer of the SPGPPS, currently Mr Phillip Taylor, as the Convenor and Chair of the SPGPPS Innovative Models Working Group.*

3. *That the SPGPPS requests that its Hospital representatives prepare a presentation concerning their views on innovative models of service delivery for the 37th SPGPPS Meeting to be held on Friday, 10 September 2004 in Perth. The presentation should be forwarded to the SPGPPS Secretariat no later than Friday, 27 August 2004 for circulation with the agenda and papers for the 37th Meeting.*

4. *That the SPGPPS requests that its Consumer and Carer representatives prepare a presentation on what services Consumers and Carers would like to receive from hospital–based settings for the 37th SPGPPS Meeting to be held on Friday 10 September 2004 in Perth. The presentation should be forwarded to the SPGPPS Secretariat no later than Friday 27 August 2004 for circulation with the agenda and papers for the 37th Meeting.*

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 ISWG could not commence work on this long–term goal until the new *AMA Agreement for Services 2004–2006*, came into effect on 1 January 2004. The Chair of the ISWG, Dr Bill Pring was invited to address the Meeting on developments.

3.2.1 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. Health Fund representatives requested that the SPGPPS discuss this matter, with a view to asking Mr Morris–Yates, to carry out a more in–depth and accurate assessment of these admissions using data from the SPGPPS Centralised Data Management Service (CDMS). Dr Pring reported that Mr Morris–Yates will be providing some initial information to Mr Peter Callanan and then it will be possible to obtain some information, which will be discussed by the ISWG and referred to the SPGPPS.

3.2.2 Third ISWG Meeting

Dr Pring then reported verbally on the third meeting of the ISWG, held on 10 June 2004 to coincide with this meeting of the SPGPPS. The SPGPPS noted that the meeting developed and prioritized a draft set of terms of reference and work plan in accordance with what Mr Morris–Yates will be able to accomplish, given the on–going work involved in maintenance and governance of the SPGPPS's CDMS and Mr Morris–Yates reduced hours.

Dr Pring reminded the SPGPPS that the agreed initial round of funding to implement the SPGPPS National Model and the CDMS, ended on 4 June 2004. Mr Allen Morris–Yates, services were retained by the AMA in order to support the continued operation and further development of the SPGPPS's CDMS, and also to support Hospitals in their implementation and utilisation of the National Model.

The SPGPPS noted that as at 31 May 2004, Mr Morris–Yates will have accrued 22 days of recreation leave. By 31 December 2004, he will have accrued a further 8 days – coming to a total of 30 days. As that leave must be taken before 31 December 2004, and given that he will be working 3 days a week, this will mean that between June 14 2004 and 31 December 2004, Mr Morris–Yates will have the equivalent of 11 full weeks of work time available in that period.

Dr Pring then outlined the general work goals of the ISWG as set out below.

GENERAL WORK GOALS 2004–2006	Actions/Time Frames
1. Re–development of the SPGPPS website to better promote the work of the SPGPPS, CDMS, and the National Network of Private Psychiatric Sector Consumers and Carers.	This work has been commissioned and will be completed before the end of 2004.
2. Ensuring that the current integrity and security of the SGPPS National Model is maintained, as the various conceptual issues that underpin the Model change. These include changes to:	
(a) the Hospital Casemix Protocol (HCP);	Mr Callanan to clarify Australian Government requirements regarding the reporting of Outreach care under the HCP before the end of 2004.
(b) the clinician rated (HoNOS) and consumer rated (MHQ–14) outcome measures currently in use; and	Mr Morris Yates will undertake redevelopment of the MHQ–14 Scoring Algorithm in 2004. The task will take approximately 60 working days.
(c) changes in how data is collected, for example, on Day Only Patients; and	Hospital and Australian Government representatives on ISWG to maintain a watching brief on this issue.
(d) 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.	To assist the ISWG in its review of this issue, Mr Morris–Yates will prepare a discussion paper in the second half of 2005.
3. Review of the current CDMS Quarterly Reports for Hospitals and Health Funds and provision of advice on any necessary changes.	The ISWG, with the assistance of Mr Morris–Yates, will undertake this Review in the first half of 2005.
4. Development of a framework for training and implementation support groups at the local level to ensure the sustainability and integrity of the SPGPPS National Model for the Collection and Analysis of a Minimum Data Set with Outcome Measures for Private, Hospital–based Psychiatric Services (National Model).	There is evidence that this is already occurring and the ISWG role should be one of encouraging the development of such local support groups. Current funding does not permit work being undertaken beyond that level.
5. Review of the existing Risk Management strategies for the National Model and the Centralised Data Management Service (CDMS).	The ISWG is currently undertaking this work.
6. Development of new outcome measures of consumer and carer satisfaction, to address their perceptions of care, and their perceived needs.	The ISWG has referred this matter to the APHA Psychiatric Sub–committee for it to work with the National Network and the SPGPPS Representative on the ISC.
7. Improvement of the understanding of the CDMS and publication of its value, and research potential, widely through relevant journal articles, press releases, conference presentations and collaborative relationships with relevant academic organisations.	ISWG agreed that individual SPGPPS stakeholder organisations needed to address this issue. Current funding does not permit Secretariat Staff to undertake this work.
8. Accurate assessment of the issue of psychiatric admissions to non–psychiatric private hospitals.	Mr Morris–Yates will prepare material to present to the ISWG to enable them to develop a specification for exactly what questions need to be asked of the HCP data held by the Australian Government.

The ISWG identified issues of IT governance, how the CDMS data is used and the limitations on the use of the CDMS data. The ISWG also identified the need to assist the SPGPPS with informational need associated with particular issues, like the issue of psychiatric/non–psychiatric beds.

Dr Pring reported that Mr Morris–Yates had demonstrated the improvements to the HSMdb software, which will enable Hospitals and psychiatrists to see the patterns of practice. Statistical elements have been added to the database so that Hospitals will be able to analyse the significance of trends or differences in the data The changes will enhance the utility of the data for Hospitals.

Dr Pring reported that Mr Morris–Yates would also be working with Mr Peter Callanan over the coming months to address the problems with the Hospitals Casemix Protocol (HCP) associated with the reporting of Outreach care.

RESOLVED (unamoiusly)

1. *That the SPGPPS approves and adopts the Report of the Second Meeting of SPGPPS Information Strategy Working Group held on 11 March 2004.*
2. *That the SPGPPS requests the SPGPPS Information Officer, Mr Allen Morris–Yates, prepare material to present to the Information Strategy Working Group (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.*

3.3 SPGPPS SUBSTANCE ABUSE AND DEPENDENCY WORKING GROUP (SDWG)

The Chair reported that, on 20 June 2003, the 32nd Meeting of the SPGPPS agreed that substance abuse and dependency was a major issue for private sector mental health services. This matter was referred to the IMWG for it to investigate and advise SPGPPS on the current treatment and care of substance abuse and dependency, in respect of both alcohol and other drugs, in the private sector, particularly in relation to:

1. what models are being used in private hospitals for the treatment of substance abuse and dependency, including the extent to which the more complex needs of patients with dual diagnoses are being adequately addressed;
2. how the treatment of substance abuse and dependency is being funded; and
3. what is currently known about best practice in respect of the types of care required by patients with substance abuse or dependency problems.

IMWG advised that this would be a complex and potentially costly task. Additional specialist expertise in the area of the treatment of substance abuse and dependency would be required and the work would take at least 12–18 months to complete. On 12 September 2003, the 33rd SPGPPS Meeting agreed that this work should proceed and the Substance Abuse and Dependency Working Group (SDWG) was established to advise on the development of a *Substance Abuse and Dependency Project Brief.* The SPGPPS asked that the Project Brief clearly set out:

- what questions are to be addressed by the project;
- what tasks need to be completed to answer those questions; and
- how the Project is to be funded.

SDWG first met on 24 November 2003 and decided that, given the complexities of the issues involved, several further meetings would be required to determine an appropriate way forward. In the interim, the following SDWG recommendations were adopted and endorsed by the 34th Meeting of the SPGPPS held on 28 November 2003.

1. *That the SPGPPS Substance Abuse and Dependency Working Group recommends its Chair approach Ms Fiona Shand, Project Officer for the development of the National Drug and Alcohol Research Centre's (NDARC) Guidelines for the Treatment of Alcohol Problems, to:*

   (a) obtain a copy of the schedule of the NDARC Guidelines Workshops;

   (b) explore the feasibility of devoting a workshop to the private sector to coincide with the release of the NDARC Guidelines; and

(c) invite Ms Shand to attend and address the first meeting of the SPGPPS in 2004 on the NDARC Guidelines.

2. That the SPGPPS Substance Abuse and Dependency Working Group recommends the following steps be undertaken to better understand the current treatment and care of substance abuse and dependency, in respect of both alcohol and other drugs, in the private sector.

(a) Mr Allen Morris–Yates, in consultation with members of the SDWG, to construct a profile of current practice in the private sector in relation to treatment of alcohol and substance abuse using data from the SPGPPS Centralised Data Management Service, and other sources.

(b) Establishment of a strong linkage with the National Drug and Alcohol Research Centre in Sydney.

(c) Invite the RANZCP Section of Alcohol and Other Drugs to indicate what current activities in relation to substance abuse and dependency they are involved in and what activities they might be interested in undertaking through proactive partnerships with the SPGPPS, and other relevant organisations, particularly in relation to promoting best practice.

The SPGPPS noted that, in accordance with these recommendations, the SPGPPS Chair, Dr Yvonne White, had invited Ms Fiona Shand to attend and address this meeting of the SPGPPS. The SPGPPS Secretariat also obtained and published the schedule of workshops for the NDARC Guidelines in the first edition of *SPGPPS News* for 2004. On 12 March 2004, the 35th Meeting and Planning Day of the SPGPPS agreed that SDWG should reconvene to review its membership and further progress its recommendations following Ms Shand's presentation.

3.3.1 PRESENTATION ON THE NDARC GUIDELINES

The Chair welcomed Ms Fiona Shand to the meeting. Ms Shand outlined the development, implementation and overview of the *National guidelines for treating alcohol problems.* This NDARC project commenced two and half years ago with funding from the Australian Government Department of Health and Ageing, and with input from a panel with a range of expertise including GPs, psychiatrists, and psychologists across a number of fields.

History of Treatment Guidelines

Treatment Guidelines in mental health came about following the events at Chelmsford Hospital, but prior to the enquiry, prompted by discontent with some psychiatric practices. Guidelines were developed for a range of major mental disorders, signifying the beginnings of evidence–based medicine in mental health. Following on from that, alcohol and other drug guidelines were developed in the early 1990s. The document titled, *An outline for the management of alcohol problems: Quality assurance project*, was developed in 1993 and this was the forerunner of the current document, *National guidelines for treating alcohol problems.*

Advantages of Treatment Guidelines

- Central resource for clinicians and researchers
- Evidence–base for organisational and clinical decision making, education and training
- Evidence–based treatment does not rule out individualised treatment or clinical judgement, criticisms, which have been made in the past.

Disadvantages of Treatment Guidelines

- Implementation/dissemination issues

- Perception that they override clinical expertise
- Liability issues
- Lack of evidence
- Translating research into clinical practice

The current Guidelines reflect the use of clinical experience from an expert panel where the research revealed a lack of evidence for what works or what is harmful.

Development of the Guidelines

Developing the Guidelines involved taking the 1993 Quality Assurance Project, as a basis reviewing the research over the last ten years, and updating the document under the guidance of the expert panel. The first document to be published on the project was a review of the evidence that supports what treatment works. The new *National Alcohol Treatment Guidelines* were published in June 2003.

Summary Guidelines are now available for GPs, hospital medical staff and alcohol and drug professionals. The summary Guidelines for drinkers and young people are currently in print. The possibility of tailoring a set of Guidelines for psychiatrists and other mental health professionals has been discussed.

Content of the guidelines

The contents of the Guidelines are broad and are aimed at a range of providers. They include the following.

- Screening instruments
- Matching the treatment to the client
- Valid and reliable assessment instruments
- Withdrawal management best practice
- Impact of treatment setting
- Brief interventions
- Psychosocial interventions
- Relapse prevention including pharmacotherapy
- Aftercare
- Specific groups: cognitive impairment, women, co–morbidity, indigenous, young people
- How to put it together in various treatment settings

Other resources

Ms Shand provided a list of other resources available, by no means exhaustive, which include the following.

- The effectiveness of interventions for illicit drug use (Gowing, Proudfoot, Henry–Edwards, Teesson, 2001)
- DVA guidelines and The Right Mix materials
- Drug and Alcohol Nurses Australasia (DANA) Nursing guidelines for alcohol, tobacco & other drugs
- NSW Health withdrawal management guidelines

- Turning Point treatment guidelines
- SNAP Network guidelines
- NCETA Update of Medical Practitioners Handbook (AOD)
- NH&MRC Australian Alcohol Guidelines
- Recent drug strategy monograph on comorbidity (Teesson & Proudfoot 2003)

In addition to the above, the Department of Health and Ageing has produced an eight–page brochure listing the resources they have produced regarding the treatment of alcohol problems. Copies of the materials may be obtained by writing to phd.publications@health.gov.au.

Implementation Project

The NDARC implementation project is funded by Department of Health and Ageing and is primarily aimed at Alcohol and Other Drugs sector. One hundred workshops across Australia are being conducted and these have been limited to 15 people per workshop. There have also been conference presentations and a media campaign. The expert panel has become a powerful advocate for the Guidelines and there have been discussions with universities and TAFEs about providing the Guidelines as a resource. Patient–driven change is being progressed through the *Drinker's Guidelines* and there have been mail outs to the alcohol and other drugs sectors, and to other sectors.

Other Implementation Initiatives

NDARC has been asked to develop a computerised decision support system based on the Guidelines. Workshops have been aimed at other health care sectors, e.g. nurses' teaching hospitals, practicing nurses, psychologists, and psychiatrists. NDARC has had some brief discussions with RANZCP. A current project funded by AERF is aimed at increasing GP intervention.

Research on implementation

Ms Shand reported that a recent study looked at how willing clinicians were to change and how this might influence implementation. A review by *Grol and Grimshaw 2003*, looked at 50 studies, which supported NDARC's view that large conferences and workshop groups had mixed effects in implementation practices and small interactive groups had more positive effects.

Educational outreach by experts or trained facilitators was particularly beneficial for prescribing behaviour and prevention. Research on using opinion leaders to change practices has shown both positive and negative outcomes.

Use of reminders for both the clinician and the client had the largest average effect. Computerised decision support mechanisms were good for management decisions rather than diagnosis. Practice audits and feedback had mixed effects. The conclusion drawn was that combined intervention strategies were more effective than single interventions. The ideal is to address change at different levels, i.e. wider environment, organisation, team, health care provider and finally at the patient level.

Discussion

The Chair asked Ms Shand whether NDARC was working in schools. Ms Shand responded that when the Guidelines for young people were finalised, NDARC intended to run workshops in schools, universities, youth groups and community groups.

Dr Kable reported that at a recent seminar on co–morbidity of alcohol and abuse and mental health problems in youth, the young seminar presenters pointed out that their greatest difficulty was not treatment but structural problems. The systems are fragmented and definitions of

'youth' vary from jurisdiction to jurisdiction. Co–morbidities are not handled well in the public sector, because groups treat alcohol and drug problems, but not mental health problems and vice versa.

Ms Shand reported that the workshops have been well received and participants have been well disposed to implement the Guidelines, particularly in rural areas and among professions not traditionally working in the drug and alcohol rehabilitation sector.

While there has been a smattering of participation by the private sector in the workshops, Ms Shand indicated that the workshops are organised through the local drug and alcohol network, which is typically a public sector facility.

Dr Nothling reported that in testing 200 workers, claiming compensation for workplace injuries, for substance abuse, 6–7% tested positive for alcohol problems and 14% tested positive for cannabis, over a period of 18 months. Dr Nothling reported that there was little research comparing these findings to other studies of substance abuse in the community at large. Ms Shand indicated that most of their data relied on self–report, which was found to be generally reliable. Ms Suzie Saw advised that the National Survey on Mental Health and Well Being had extensive data on co–morbidity.

Dr Lammersma expressed the view that the wealth of information and guidelines on substance abuse treatment needs to be translated into effective services in the private sector. Ms Shand reiterated that this was the objective of the implementation phase of the Project. Ms Shand explained that when the first set of Guidelines were developed, some States targeted funding to compliance with the Guidelines. Having the Guidelines in place is the first step. A multi–component strategy is required to ensure that projects have the skills and resources required to be effective.

Ms Saw raised the issue that, as the Guidelines are focused solely on alcohol dependency, they do not deal effectively with the issues of co–morbidity of substance abuse with mental health problems and the best process for handling both. Ms Shand explained that patients with co–morbidities are excluded from many studies because they are difficult to treat, and therefore it is difficult to incorporate this into evidence based Guidelines. Ms Judy Hardy indicated that current funding mechanisms in the private sector force a mental health funding model, which has issues that are difficult to address. Dr Nothling reported that the major problem for a large number of severely depressed patients is the alcoholism, not the depression, which could be alleviated by detoxification. Detoxification in a general hospital would also be detrimental to the proportion of patients who do have a serious mental disorder underlying their alcoholism.

Dr Lammersma indicated that the training of psychiatrists does not enable them to deal well with treating co–morbidity issues, possibly because of the artificial split of services in the public system. Only recently has it been understood that it was important to be able to treat both.

The Chair referred to the feasibility of conducting a workshop for the private sector. Dr Pring indicated that it might be beneficial, given that Ms Shand had had preliminary discussions with the RANZCP, for the SPGPPS to support and encourage upgrading in some way, the knowledge of psychiatrists about co–morbidities, diagnosis of substance abuse and a holistic approach to treatment. The SPGPPS Substance Abuse Working Group will progress this issue.

Ms Shand advised that the URL for downloading copies of resources is at www.nationaldrugstrategy.gov.au. Mr Taylor agreed to obtain copies of the publication, *Alcohol Resources* for the SPGPPS.

The Chair thanked Ms Shand for her presentation and the agenda resumed with the next meeting of the SDWG being left in the hands of the Chair, Mr David Morton.

4. DISCUSSION ITEMS

4.1 NAME CHANGE FOR THE SPGPPS

The Chair reported that the 35th SPGPPS Meeting and Planning Day agreed that, in consolidating its current work program, the SPGPPS needed to concentrate on the following priorities in relation to ***Communication Strategies***.

Promulgate the value of the SPGPPS to the private sector and improve the understanding of what the SPGPPS does through better communication strategies including the following.

a) Re–develop the SPGPPS website, spgpps.com, to promote the work of the SPGPPS, its CMDS and the National Network.

b) Utilise CDMS, and other data on private sector services, to demonstrate what the SPGPPS is doing.

c) Consider an appropriate name change for the SPGPPS.

d) Agree on the audience the SPGPPS wants to communicate with, why and when.

e) Stakeholders to participate more actively in the development of the SPGPPS agendas.

The SPGPPS noted that a), b), d), and e) are being progressed by the ISWG, a name change for the SPGPPS, c), requires consideration of this meeting. In considering this issue the SPGPPS further noted that it has been suggested that the title, *Strategic Planning Group for Private Psychiatric Services*, and acronym, *SPGPPS*, are too long and no longer properly reflects what the SPGPPS does. It has also been suggested that the name is dated, because it arose at a time when the future of private sector mental health services was less sure, and at a time when strategic planning was popular in management circles. It has, however, not been easy to construct an alternative. Dr Bill Pring reported that the best suggestion to date has been *Private Mental Health Alliance* or *PMHA*.

Mr Taylor reported that preliminary advice indicates that the approximate costs associated with changing the name of the SPGPPS would include the following.

Trademark Registration	$2,000
Logo Design	$4,000
Signage	$500
Total	**$6500**

Dr Pring indicated that a name change would assist in promulgating more simply the work of the SPGPPS. Some in the medical community are not aware that the group is about mental health. Dr Lammersma and Dr Kable pointed out that the problem with the current name is that psychiatric services are at the end of the title. Dr Nothling indicated that the current name does not currently reflect the work of the group and this disparity will be greater in the future.

A straw poll on a name change from SPGPPS to ***Private Mental Health Alliance*** resulted in 5 for, 3 against, with 2 abstaining. Based on the ambivalent result, Members and Observers were asked to seek the advice of their stakeholder groups in deciding if a name change is necessary and what that name change should be, bearing in mind that the concepts of alliance or partnership and mental health were generally seen by the meeting as critical in the new title.

The Secretariat was asked to include this matter on the agenda for the 37th Meeting of the SPGPPS.

RESOLVED

That the SPGPPS requests its Members and Observers to consult there constituencies and report back to the 37th Meeting of the SPGPPS concerning whether a name change is necessary for the SPGPPS. If so, Members and Observers should seek the advice of their constituencies as to whether the title, Private Mental Health Alliance, is appropriate as it captures the concepts of alliance, partnership and mental health, which the SPGPPS has agreed are critical in any new title.

4.2 PUBLIC–PRIVATE SECTOR INTEGRATION

The Chair reported that the 35th SPGPPS Meeting and Planning Day agreed that the SPGPPS needed to explore the current barriers to better integration between the private and public sector and identify what the private sector might be able offer to address those barriers for submission to the AHMAC National Mental Health Working Group. In doing so, the SPGPPS needs to consider how its activities may help bridge the gaps and progress reform of private psychiatric services across health and other related sectors.

The Chair reported that there are many issues to be addressed in encouraging better integration between the private and public sector. Private psychiatrists and consumers, for example, would like to have better access to community mental health teams. Case management in many areas of the public sector cannot be done because of lack of resources. Ms McMahon indicated that there were problems with uninsured patients who were treated by private psychiatrist but received hospitalisation in public facilities, at which point they were under the care of public sector psychiatrists with no input from their treating psychiatrist. Private patients also have difficulty obtaining a bed in private hospitals if they are detained involuntarily and therefore hospitalisation is in the public sector, if available. The Chair also referred to the problems of a lack of information for the treating psychiatrist after discharge from a public facility.

Dr Pring indicated that a lack of policy development for integration between the private and public system is possibly the greatest barrier to change. Current arrangements tend to be local and ad hoc. The second structural barrier is the lack of communication. Basic strategies to improve communication, such as promoting the use of faxes more often, rather than waiting for the development (and as yet unknown advantages) of e–health would be helpful. Dr Lammersma indicated that this problem would only be addressed through policy discussions between the SPGPPS and senior bureaucrats in all the States.

Ms Suzy Saw indicated that the interface between the public and private sectors is part of a very broad picture in terms of the provision of mental health services including the involvement of GPs as providers of primary care. Medi–connect is only now being trialled. Ms Saw referred to the complexity of the problem and cited the integration project at St Vincent's Hospital, Melbourne, where the project had an 18–month planning phase dedicated to integrating people. Private practitioners, public hospitals and community teams do not have the time for this level of very necessary planning.

Dr Kable reported that liaison committees had been set up between the local Divisions of General Practice and the local public hospitals, who have agreed to certain protocols including that the GP is faxed a copy of the discharge summary. Access to community health teams for GPs, though far from perfect, has effected an open discussion of the problems and possible solutions.

Ms Munro pointed out that the reality is that the public sector in Western Australia has cut back on resources for mental health and with their existing resources stretched, do not want to treat patients from the private sector. Integration is expensive.

Ms McMahon reported that for privately insured patients the situation is very difficult in rural and remote areas, where private sector services are not available. Consumers must either travel long distances for treatment or rely on the public system.

Dr Pring indicated that it was important to ascertain whether there are policies or protocols in place concerning private and public sector involvement governing a range of specifics. Framing the policy in terms of what the private sector has to offer, *bed overflow uptake*, for example, rather than merely access to services.

The Meeting agreed that the SPGPPS should progress this matter directly with the AHMAC National Mental Health Working Group (NMHWG). The Chair was asked to undertake preliminary discussion of this issue at the next meeting of the NMHWG to be held on Friday, 2 July 2004.

RESOLVED

That the SPGPPS requests that its representative on the AHMAC National Mental Health Working Group (NMHWG), Dr Yvonne White, explore 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 should initially be raised.

- *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.*

4.3 ACCESS TO PSYCHIATRIC BEDS

The Chair reported that the 35th SPGPPS Meeting and Planning Day agreed that 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 Chair reported that there are no private hospitals in New South Wales or Victoria, which admit involuntary patients and this is governed by State and Territory legislation.

Dr Pring suggested that the SPGPPS should write to the appropriate State and Territory health authorities to ascertain what the 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. Hospital Representatives also agreed to raise this issue with their State and Territory representatives and report back to the 37th SPGPPS Meeting.

In relation to access in rural and remote areas of Australia, Dr Pring suggested that an extra financial incentive could be provided in the proposed CMBS Report Item rebate for rural postcodes. Dr Kable reported that the uptake of the General Practice Mental Health Initiative in small rural centres has been very strong compared to urban centres.

RESOLVED

That the SPGPPS requests the Chair write 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.

5. STANDING ITEMS

5.1 AHMAC NATIONAL MENTAL HEALTH WORKING GROUP (NMHWG) REPORT

The Chair reported that the next meeting of the NMHWG would be held on 2 July 2004 in Sydney. It was noted that a copy of the NMHWG agenda had been circulated with the agenda and papers for this meeting of the SPGPPS, together with a copy of the draft minutes from the 5 March 2004 NMHWG.

The Chair reported that there had been little progress with the recommendations from the report, *Australian Mental Health Nurse Supply, Recruitment And Retention.* The SPGPPS noted that Sydney University recently decided not to offer undergraduate training nursing in favour of postgraduate programs. The Chair reported that NMHWG has established a Drafting Group comprising Australian Capital Territory, Tasmania, South Australia and New South Wales. The Drafting Group will refine a paper on workforce and work place redesign being prepared by the ACT and develop a suggested way forward, taking into consideration the above report on the nursing workforce. Mr Taylor reported that the draft paper prepared by the ACT had been recently circulated to the SPGPPS for comment and thanked those that responded.

The Chair reported that the International Institute of Mental Health Leaders had met in May 2004 and will be meeting in New Zealand in 2005. The Chair reminded the Meeting that their program involves visiting facilities for two to three days in both Australia and New Zealand. The private sector is welcome to participate in this program.

The Chair reported that the National Disasters and Terrorism Working Group was finalising its terms of reference. The Working Group has requested the States to nominate a person responsible for developments in this area.

5.2 CONSUMERS AND CARERS REPORT

The Chair of the National Network of Private Psychiatric Sector Consumers and Carers (National Network), Ms Janne McMahon reported that since the last SPGPPS Meeting, the National Network had held a two–day meeting in Melbourne that addressed the following issues.

SPGPPS Centralised Data Management Service

Dr Bill Pring and Mr Allen–Morris–Yates gave an extensive presentation on the SPGPPS Centralised Data Management Service and the implementation of the SPGPPS National Model for the Collection and Analysis of a Minimum Data Set with Outcome Measures for Private, Hospital–based Psychiatric Services.

RANZCP Complaints Handling Mechanism

Ms McMahon reported that Mr Allen White, the RANZCP Consumer Relations and Complaints Officer, provided an address on the recommendations arising from the Final Report of the RANZCP Complaints Handling Project. Dr Jo Lammersma explained that while the function of the RANZCP is to attend to the training, education and registration of its Fellows, from time–to–time, consumers and their families contact the RANZCP or it's State Branches with complaints of varying nature against psychiatrists. In April 2003, the RANZCP responded by

commissioning the Health Issues Centre to develop a consistent method of management, monitoring and referral of complaints received by the College. The Final Report arising from the Project concentrated on complaints handling and making the College more accessible to consumers and carers. The College appointed Mr White so that consumers and carers could have immediate contact and support. Complaints are reviewed by the RANZCP executive at a weekly teleconference. Ms McMahon reported that Mr White will provide the National Network with a summary report at the end of this year.

Ausinet

Ms Susan Mitchell gave a presentation on Auseinet, the organisation for the promotion, prevention and early intervention in mental health.

National Network State and ACT based Committees

Ms McMahon reported that although the National Network's State and ACT–based Committees are in the early stages of development, they are already providing useful feedback. The SPGPPS noted that Ms McMahon and Mr Taylor are meeting, wherever possible, with the State and ACT–based Committees when the SPGPPS holds a meeting in their respective jurisdiction. Ms McMahon and Mr Taylor attended the meeting of the National Network's Queensland Committee, which was held on Wednesday, 9 June 2004. The meeting was kindly hosted by the New Farm Clinic.

FAME

Ms McMahon reported that the Network had followed up the Families as Medical Educators (FAME) project, adapted to mental health. In its usual format the FAME project involves the education of medical personnel by the families of children with severe disabilities, through panel presentations, interviews with the trainee doctors, nurses and allied health professionals and home visits. Following discussions with Mr Bob Wells concerning consumer and carer involvement in education, the Network has written to Mr Wells to ascertain if an adaptation of the FAME model would be feasible as a way of demystifying and de–stigmatising mental health.

National Network Expert Advisory Panel

Ms McMahon reported that considerable progress had been made in establishing the Expert Advisory Committee, and thanked the SPGPPS Members and Observers who have agreed to be advisors.

ACHS

Ms McMahon reported that three consumers, nominated by the Network, had completed training as Australian Council on Healthcare Standards (ACHS) consumer surveyors, bringing the number of private sector consumer surveyors to four. It is hoped that the ACHS will use these surveyors, with expertise in the private sector, for the accreditation of private hospitals with psychiatric beds.

Ms McMahon reported that, at the November 2003 meeting with ACHS, it was agreed that she, Ms Heather McDonald of ACHS and Ms Moira Munro would meet to discuss the roles and responsibilities of the consumer surveyor in the private sector. This matter is yet to be resolved.

National Network Work Plan 2004–2005

Ms McMahon reported that the National Network is in the process of determining its work plan for the next 12 months and has amended its Vision Statement to read;

Engage, empower, enable choice in private mental health.

Ms Kim Werner has agreed to facilitate the National Networks Planning Day scheduled for August 2004 in consultation with SPGPPS Secretariat.

Letter to the Minister

Ms McMahon reported that the National Network was concerned by the decision of the Australian Government to allow three Health Funds to impose a 12 month waiting period for psychiatric and rehabilitation benefits only for members transferring from another Health Fund with the same level of cover. The National Network wrote to the Hon Tony Abbott, MP Minister for Health and Ageing articulating the Network's concerns about rule changes, which allow discriminatory practices by Health Funds. The Chair reported that at the AMA National Conference 2004, Dr Norman Swan raised this issue with the Minister in a Question and Answer Session. The Minister responded:

> *This is something that has slipped under my radar screen and I am not happy with it myself. I am looking at what can be done to ensure that that is either reversed or does not happen again.*

Mr Callanan reported that this benefit limitation has been in place for some time and is not inconsistent with any part of the legislation. The history is that when a Health Fund had a dispute with a Hospital group, the Health Fund members transferred to another Health Fund, which prompted the Health Fund to ask the Government for a rule change. The DHA has met with the Health Fund concerned and is currently reviewing the complex issue of *portability* in consultation with Health Funds, Hospitals and Consumer and Carer groups.

Mr Osborne counselled caution in responding to such issues in a regulated market and there was a discussion of how this situation had arisen. Dr Pring indicated that the principles of not changing the rules after having supported the concept of *portability* and not targeting psychiatric and rehabilitation services should be upheld.

5.3 HOSPITALS REPORT

Ms Moira Munro reported that Mr Allen Morris–Yates gave a presentation on the enhancements to the CDMS Hospitals Standardised Measures database application (HSMdb) reporting function at the last meeting of the APHA Psychiatric Sub–committee. The presentation generated useful discussion about the understanding and use of the data by Hospitals and the possibility of setting up State user's groups. Hospitals in Queensland are already setting up a half–day workshop to promote better understanding of the CDMS data and what can be done with it. Portability was the other issue discussed and the APHA had sent similar correspondence concerning this issue to relevant stakeholders.

5.4 PSYCHIATRISTS REPORT

Dr Lammersma advised that the report on the survey of psychiatrists on access to private mental health services and a range of other issues would be included in the agenda and papers for the next meeting of the SPGPPS. The College has decided to repeat this survey annually. Dr Lammersma reported that the response rate to the survey was 60%.

Dr Lammersma reported that the new written and clinical examinations had been successfully held, with a slightly higher pass rate than under the old system. The new system requires much more involvement of people in the examination process, which has led to a bottleneck of clinicians waiting to be tested.

Better Outcomes In Mental Health Care Initiative (BOIMHC)

Dr Lammersma reported on developments with the Australia Government's 2001–2002 Federal Budget BOIMHC Initiative. This Initiative is directed toward improving primary mental health services by supporting GPs in their role of providing services to people with a mental health problem. Dr Lammersma explained that BOIMHC Initiative is comprised of:

1) education and training for GPs;
2) a 3 Step Mental Health Process;
3) a Medicare Benefits Schedule (MBS) Item for GP Focussed Psychological Strategies;
4) access to allied health services; and
5) access to psychiatrist support.

Dr Lammersma reported that the initiative is improving the community's access to primary mental health services by providing better education and training for GPs and support from allied health professionals and psychiatrists.

As part of the Initiative, a new service recently commenced that provides GPs with access to urgent patient management advice. The *Access to Urgent Patient Management Advice from a Psychiatrist Service*, as it is known, addresses the fifth component of the BOIMHC Initiative by providing GPs with quality clinical advice from psychiatrists within 24 hours, on management and/or treatment of patients with a mental health problem or disorder. GPs can access the Service in situations they judge as having the potential to escalate into a more serious problem without prompt intervention, but not requiring emergency intervention at the time of patient contact with the GP. Dr Lammersma reported feedback from GPs and psychiatrists concerning the Service has been very positive. Dr Lammersma reported that the College continues to work with GP groups to form better working relationships and better liaison. In South Australia, for example, the *Access to Urgent Patient Management Advice from a Psychiatrist Service* Group of approximately 30 psychiatrists have undertaken to provide physical assessments within two weeks.

Dr Lammersma then reported that BOIMHC is funded until June 2005 and is currently undergoing evaluation. Ms Suzy Saw explained that BOIMHC is a lapsing program and that it is a requirement of the Australian Government that lapsing programs be evaluated. Future funding will be contingent on assessment of the overall success of the Initiative and it is anticipated that a Final Evaluation Report will be available in September 2004.

MBS Items

Dr Lammersma reported that the College had looked at MBS Item changes to enhance collaborative care between GPs and psychiatrists as well as the issues of case conferencing and telepsychiatry. At the meeting of the College held with the DHA in February 2004 these matters were discussed, along with MBS Item 319. At that time, a compromise was reached which would withdraw the restrictions imposed by 319, and replace it with some form of peer reviewed entry to 50 consults per year. However, after several months of consultation, it was decided at a meeting this week that 319 would not be modified, and could possibly be addressed through the Medicare Plus arrangements. Following discussion, Dr Nothling reported that the AMA would hold a meeting shortly to look at the analysis of costs and benefits of Item 319 compared to the proposed arrangements for Medicare Plus. The College will be pursuing the telepsychiatry MBS Item, but not the case–conferencing Item for the time being.

Correspondence

Mr Taylor reported that in relation to the correspondence from Dr C Nick De Felice concerning the restriction of benefits for ECT treatments to 12 per year, he had written to Dr De Felice stating that the SPGPPS had comprehensively dealt with this issue in the past resulting in the issue of a circular from DHA.

Mr Callanan reported that the issue of a mother admitted for psychiatric treatment, and Health Funds refusing to pay benefits for the baby has arisen in the past. Hospitals have pointed out that for medico–legal reasons a baby must be formally admitted as a boarder to a psychiatric

facility and incurs a cost for care. As a boarder, the baby cannot be insured. Mr Osborne has offered to contact the Health Fund concerned and ensure a response is sent to Dr Galambos.

5.5 GENERAL PRACTITIONERS REPORT

Dr Kable reported that the General Practice Mental Health Standards Collaboration (GPMHSC) has received funding until March 2005. Work is now focussed on identifying gaps in the educational provisions and promoting innovative models for rural and remote GPs. GPMHSC will be promoting the BOIMHI in collaboration with the Mental Health Council of Australia. The Standards have been revised and accepted by the Australian Government for the next triennium. Built into the Standards are some operating guidelines, which providers must comply with. Providers must include consumers and carers in levels 1 and 2 in their planning and consider using consumers and carers in the delivery of training. The group is also more involved in quality assurance and auditing of approved training courses. At the last meeting of the GPMHSC Advisory Group a paper was presented from DHA on incorporating the elements of the initiative into participant's usual programs, which the Advisory Group is not in a position to do. Dr Kable advised that he would like to see the initiative change from a program to a policy unit. RACGP is encouraging the incorporation of mental health into the registrar training. Western Australia has incorporated Level 1 training as part of their registrar's training.

5.6 HEALTH FUND REPORT

Mr Osborne reported that Health Fund issues had been adequately addressed under Agenda Item 3.1.1.

5.7 AUSTRALIAN GOVERNMENT REPORT

Mr Callanan reported that the 2nd Tier benefits issue is still with the Minister for Health. From 1 July 2004, there will be a cost to Health Funds of $2000 to lodge a 3B certificate.

Ms Saw reported that the proceedings from the AHMAC NMHWG Information Strategy Committee (ISC), *Mental Health Information Priorities Workshop*, held in February 2004, have been published. It was noted that SPGPPS Secretariat had circulated a copy of this document in the agenda folder for this meeting under Agenda Item 9.1 of the ISWG agenda papers. Ms Saw indicated that the proceedings would be used to develop the Information Framework, a document setting out the key information priorities, principles and consolidation of current initiatives. Ms Saw reported that at the last meeting of the ISC, it was agreed that effort would be directed at developing a perception of care measure.

6. NEXT MEETING

The next meeting of the SPGPPS will be held on Friday, 10 September 2004 at the Perth Clinic Clinic, 29 Havelock Street, West Perth. The meeting will commence at 9:00 AM and conclude at 4:00 PM. Ms Moira Munro will chair this meeting in the absence of Dr White. It was agreed that an SPGPPS Dinner should be held on the evening of Thursday, 9 September 2004.

7. CLOSE

There being no further business, the Meeting closed at 4:30 PM. In doing so the Chair thanked Ms Sue Feeney and the staff of the New Farm Clinic for hosting this meeting of the SPGPPS.

Dr Yvonne White
Chair

Mr Phillip Taylor
Secretary