STRATEGIC PLANNING GROUP FOR

SPGPPS

PRIVATE PSYCHIATRIC SERVICES

TWENTY–EIGHTH MEETING
HELD AT
THE NEW FARM CLINIC
22 SARGENT STREET
NEW FARM
BRISBANE
ON
FRIDAY, 7 JUNE 2002

REPORT OF MEETING

Glossary of Acronyms and Terms used in this Report

ACHS	Australian Council on Healthcare Standards
AHIA	Australian Health Insurance Association
AHMAC	Australian Health Ministers' Advisory Council
APHA	Australian Private Hospitals Association
AMA	Australian Medical Association
CCPs	Clinical Care Pathways
CDHA	Commonwealth Department of Health and Ageing
CDMS	Centralised Data Management Service
CDP	Community Development Project
CPGs	Clinical Practice Guidelines
Health Fund(s)	Private Health Insurance Fund that pay benefits for psychiatric care
HFPCLG	Health Fund Psychiatric Care Liaison Group
Hospital(s)	Private Hospital with psychiatric beds
MBCC	Medicare Benefits Consultative Committee
MHCA	Mental Health Council of Australia
MHPC	Mental Health Privacy Coalition
NCCF	AHMAC National Consumer and Carer Forum
NMHS	National Mental Health Strategy
NMHWG	AHMAC National Mental Health Working Group
NOAC	Network of Australian Consumer Advisory Groups
OFPC	Office of the Federal Privacy Commissioner
RACGP	The Royal Australian College of General Practitioners
RAMWAC	Review of the Australian Medical Workforce Advisory Committee
RANZCP	The Royal Australian and New Zealand College of Psychiatrists
SPGPPS	Strategic Planning Group for Private Psychiatric Services

The Twenty–Eighth (28th) Meeting of the SPGPPS was held on Friday, 7 June 2002 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 10:00 AM. The following representatives were in attendance.

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

1. Dr Yvonne White — Chair SPGPPS
2. Dr Jim Rodney — Proxy for Dr Jo Lammersma
3. Mr Craig Patterson — (Observer)

Australian Medical Association (AMA)

4. Dr Bill Pring — Chair, SPGPPS Data Collection and Analysis Project
5. Dr Choong–Siew Yong — (Observer)

The Royal Australian College of General Practitioners (RACGP)

6. Dr Brian Kable

Commonwealth Department of Health and Ageing (CDHA)

7. Mr Mick O'Hara — Mental Health Branch and Special Programs Branch
8. Mr Peter Callanan — Private Health Industry Branch
9. Ms Margaret Noris — Observer, Private Health Industry Branch
10. Ms Yvette Costmeyer — Observer, Private Health Industry Branch

Private Hospitals with Psychiatric Beds (Hospitals)

11. Ms Sue Feeney
12. Ms Moira Munro

Private Health Insurers (Health Funds)

13. Mrs Judy Hardy

SPGPPS Secretariat

14. Mr Phillip Taylor — Executive Officer
15. Mr Allen Morris Yates — Principal Information Officer
16. Ms Jane Ferry — SPGPPS Legal Counsel

Apologies

6. Mr Dermot Casey — CDHA Mental Health and Special Programs Branch
7. Mr David Morton — Department of Veterans' Affairs
8. Dr Jo Lammersma — RANZCP
9. Ms Laurel Mitchell — Health Funds

Invited Guests

1. Mr Brian Johnston — Australian Council on Healthcare Standards (ACHS)

1.2 REPORT OF THE 27TH MEETING OF THE SPGPPS

The SPGPPS considered a copy of the draft report of its 27th Meeting held on Thursday, 14 March 2002 in Sydney. The report was approved as a true and accurate record of proceedings.

RESOLVED (Dr Kable/Mrs Hardy)

1. *That the SPGPPS approve, as a true and accurate record, the report of the 27th Meeting of the SPGPPS held in Sydney on 14 March 2002.*
2. *That the SPGPPS directs that the Report of the 27th Meeting of the SPGPPS be made available on the SPGPPS Website at: www. spgpps.com.*

1.3 PROGRESS REPORT ON ACTIONS ARISING FROM THE 27TH MEETING

The SPGPPS noted the following Progress Report on Actions Arising from the 27th Meeting of the SPGPPS**.**

	AGENDA ITEMS	ACTION OFFICER(S)	STATUS
1	***PROCEDURAL MATTERS***		
1.1	**OPENING, WELCOME AND APOLOGIES**		
➢	Letter to Ms Lynn McDonald–Duke	Secretariat	Done
1.2	**REPORT ON THE 27TH MEETING OF THE SPGPPS**		
➢	Draft and circulate report for comment	Secretariat & Chair	Done
➢	Post Report on the SPGPPS website	Secretariat	Done
1.3.1	**CONSUMER AND CARER PARTICIPATION.**	Secretariat	
➢	Hospitals to hold first teleconference	Hospitals	Done
1.4.1	**AHMAC NMHWG**		
➢	Follow up SPGPPS membership on NMHWG	Secretariat	Done
1.4.2	**PRIVATE SECTOR PRIVACY LEGISLATION**		
➢	Secretariat to co–ordinate coalition meeting	Secretariat	Done
➢	Secretariat to co–ordinate coalition teleconference	Secretariat	Done
2	***FINANCIAL AND OPERATIONAL MATTERS***		
2.1	**SPGPPS ANNUAL PROGRESS REPORT**		
➢	Circulate final version to Parties to *AMA Agreement*	Secretariat	Done
➢	Reminder notice to CDHA/AHIA Year 2 contributions	Secretariat	Done
➢	Post final version on SPGPPS website	Secretariat	✔***Pending***
2.2	**SPGPPS STRATEGIC PLANNING DAY**		
➢	Post report on Planning Day on the SPGPPS website	Secretariat	Done
➢	Obtain information on current status of nursing shortage	Hospitals	✔***Pending***
➢	Obtain information on current status of psych workforce	RANZCP	✔***Pending***
➢	Secretariat to collate information for 28th Meeting	Secretariat	Done
➢	Arrange facilitator for 2002 Strategy Day	Secretariat	Done
2.3	**FUTURE LEADERSHIP OF THE SPGPPS**		
➢	Agenda Item 28th Meeting	Secretariat	Done
➢	Co–ordinate informal monthly SPGPPS teleconferences	Secretariat	Done
2.4	**SPGPPS National Forum 2002**		
➢	Approach Prof. Whiteford to do background work	Secretariat	Done
➢	Advise on costs of background work	Secretariat	Done
➢	Establish Forum Agenda Committee	Secretariat	Done
2.5	**SPGPPS DATA COLLECTION AND ANALYSIS PROJECT**		
➢	Post *Progress Report 2* on SPGPPS website	Secretariat	Done
3	***DISCUSSION ITEMS***		
3.1	**MHCA NATIONAL CONSUMER & CARER FORUM**		
➢	Letter to MHCA – conditions on funding for NCCF reps	Secretariat	Done
➢	Co–ordinate interim reps for April 15/16 NCCF	Secretariat	Done
➢	Health Funds & Hospitals to consider SPGPPS position	Health Funds/Hospitals	Done
3.2	**COMMUNITY DEVELOPMENT PROJECT**		
➢	Stakeholders to bring CDP to attention of constituencies	All	Done
➢	Article SPGPPS Newsletter	Secretariat	Done
3.3	**REVIEW OF GUIDELINES FOR DETERMINING BENEFITS**		
➢	Amend Guidelines as per 27th Meeting & circulate	Secretariat	Done
➢	Stakeholders to discuss with constituencies	All	Done
➢	Prepare final version for 28th Meeting	Working Group	Done
3.4	**SAFETY & QUALITY IN MENTAL HEALTH**		
➢	Letter to Dr Tobin re: SPGPPS nominee	Secretariat	Done
3.6	**TRANSFER OF ACCREDITATION STATUS**		
➢	Letter to ACHS	Secretariat	Done

The SPGPPS then considered the following outstanding matters.

1.3.2 WORKFORCE ISSUES (27th Meeting Agenda Item 2.2)

- ***Mental Health Nursing Workforce***

The Secretariat advised the meeting that there has been a major injection of funds into Charles Sturt University, the University of Technology Sydney, and Newcastle University to increase the supply of mental health nurses. Victoria has introduced a program to recruit and retain nurses and all States are making similar arrangements. A National Review of Nursing Education is also due to report in October 2002 and there is also a Senate Inquiry into nursing going on at present. The Secretariat reported that the view of the Royal Australian and New Zealand College of Mental Health Nurses was that despite these developments, many mental health nurses remain pessimistic about the current situation improving, without significant improvements in working conditions and career opportunities.

Hospitals reported that the APHA Nursing Taskforce has not met since March 2002. The Taskforce has, however, forwarded a submission to the National Review of Nursing Education. A copy of the submission was tabled and noted. The Secretariat was asked to circulate the submission with the draft report of this meeting. The CDHAC indicated that nursing workforce issues would also be considered at the 14 June meeting of the AHMAC National Mental Health Working Group (NMHWG).

- ***Psychiatrist Workforce***

Mr Craig Patterson reported that the RANZCP would be meeting shortly to look at the data the College currently holds on its fellows and how that data might be used to inform the workforce debate. The RANZCP has also written to the NMHWG seeking a meeting between the Executives of the RANZCP and the NMHWG to discuss possible alternatives to previously agreed RAMWAC process. The College remains committed to addressing the recommendations made in the original Australian Medical Workforce Advisory Committee (AMWAC) report, *The Specialist Workforce in Australia: Supply and Requirements 1999–2010*. This commitment includes issues relating specifically to the specialty of psychiatry and to proposed solutions for the broader mental health workforce. The agreed RAMWAC directions, however, are no longer viable from the RANZCP's perspective, but the College believes that alternative partnership approaches to a response to the AMWAC report are achievable. The CDHAC reported that this matter was also on the agenda for the 14 June 2002 meeting of the NMHWG.

RESOLVED

That the SPGPPS Requests the Secretariat to circulate the Australian Private Hospitals Association submission to the National Review of Nursing Education to the SPGPPS with the draft report of the 28th meeting.

1.4 OUT OF SESSION DECISIONS

1.4.1 MENTAL HEALTH PRIVACY COALITION (MHPC) REPORT TO SPGPPS

The SPGPPS is co–ordinating the endeavours of the Mental Health Privacy Coalition in the sensible application of the *Privacy Amendment (Private Sector) Act 2000*, which extended the *Privacy Act 1988* to cover the private health sector. The Coalition is constituted by representatives from the AMA, RANZCP, APHA and the MHCA.

Dr Yvonne White reported that the Coalition met with the Privacy Commissioner, Mr Malcom Crompton at the Australian Government Solicitors Office in Sydney on 8 May 2002. The purpose of the meeting was to consider the impact on the mental health sector of the legislation, its 10 National Privacy Principles (NPPs), and the *Guidelines on Privacy in the Private Health*

Sector (hereafter Guidelines). Mr Crompton, chaired the meeting and the following MHPC representatives were in attendance.

RANZCP
Dr Yvonne White
Dr Craig Patterson

AMA
Dr Bill Pring
Ms Pam Burton

Office of the Federal Privacy Commissioner (OFPC)

Mr Malcolm Crompton	Federal Privacy Commissioner
Mr Paul Armstrong	Director Policy
Ms Martine Magers	Senior Policy Adviser
Mr Timothy Pilgrim	Australian Government Solicitors Office

APHA
Mr Bernard McNair
Mr Paul Mackey

MHCA
Mr John McGrath

AHIA Observer
Mrs Judy Hardy

SPGPPS Observer
Mr Phillip Taylor

Apologies

Janne McMahon	Consumer Representative

Dr White reported that Mr Crompton provided an overview of the consultation processes undertaken by the OFPC in developing the new legislative framework and its accompanying documentation. He made it clear that discussion of legislative changes was not on the agenda.

The SPGPPS noted that, at the meeting, the AMA provided an introductory presentation and explained that the MHPC was broadly supportive of the legislative framework. The MHPC acknowledged that, while the Privacy Commissioner was unable to change the existing legislation, he is able to influence the Guidelines and make public interest determinations.

Dr White reported that the MHPC then identified the following key issues and Mr Crompton provided each of the MHPC stakeholders with an opportunity to speak to these issues and provide examples.

Definition of Primary Purpose

The MHPC identified that best health–care practice requires a holistic approach to the patient and that this is particularly important in mental health care. The preamble to the Guidelines acknowledges that the doctor's prime concern is the health care of the patient. However, the Guidelines assume a more episodic approach to health care. Whilst the episodic approach to health–care might suit a market–based view of health care delivery, consumers, carers and service providers are agreed that a holistic community–based approach to health care is much more ideal. Some believe it should be the default approach to health care service provision, in applying the privacy principles. Consumers can, at the outset of treatment with their doctor, elect to take a non–holistic approach if they so desire, but they should be made aware of the potential dangers of such an approach at the outset.

Consent

The MHPC explained that concerns with this issue were significantly associated with the

previous problem of the narrow view taken of *primary purpose*. Increasingly, providers are becoming involved in private provision of health care delivery in the community, and this is certainly already the case with mental health care. Integration of the treatment provided by a number of providers in the community is a vital part of seamless health care delivery. Such integration requires the sharing of health care information about consumers under strict considerations of privacy and confidentiality.

The MHPC expressed the view that consumers should be integrally involved in a process of consent regarding sharing of information, but that the process should be ongoing rather than episodic, in a holistic treatment program. Giving consent at the beginning of treatment is important. It is even more important, however, that there is continual obtaining of consent, as required, as part of the ongoing therapeutic relationship, rather than a prescriptive consent requirement that might be destructive of that relationship. Such ongoing consent cannot be easily legislated for and a mountain of paper recorded or signed consent impedes the therapeutic process. Particular treatments and procedures have always required specific consent, such as ECT.

Consumers and carers are most concerned that when consent forms are signed, the consumer is fully competent at the time. This is a sensitive issue, and it was noted that the reality of mental illnesses is that they can subtly render many people less than competent, especially at the beginning of an illness.

Access

The MHPC had agreed that, while consumers must have ready access to much of their medical records, there are parts of the mental health record that relate to the doctor's own thoughts concerning the patient (sometimes called *process notes*), and also comments that may have been received from carers about the patient. In certain circumstances, the privacy legislation permits removal of some information, which relates to the personal thoughts of the doctor, or comments from the relatives that may cause serious harm to a patient, or another person. Unfortunately, such whiting out or removal of the comments is likely to be quite unsatisfactory for the consumer. It may raise more questions than it answers. If a mechanism is not arranged to deal with this issue, the MHPC predicted that it is likely to perversely produce a change of record keeping which will not be in line with the privacy principles.

Giving reasons for restricting access

The MHPC pointed out that the current legislative regime provides that the patient is to be given a reason for the refusal to provide access to the record. In mental health there is a danger that in providing the patient with a reason, the practitioner may in fact be revealing the very information that could be harmful to the patient.

Refusal for reason of "serious harm".

Of more concern to the MHPC, is the need for there to be serious harm to a person, before restriction of access is permitted. The MHPC believes that access to the interactive therapeutic notes might interfere with the therapeutic relationship, without there necessarily being serious harm. The threshold test of serious harm is inconsistent with the doctors imperative that the patient's wellbeing is paramount.

Resolving disputes of access

The MHPC indicated that that it was not clear what sort of process would be involved in resolving a dispute between the patient and the health care provider over access, that did not disrupt the therapeutic relationship.

The MHPC raised the question as to what the situation is in terms of indemnification when a health–care provider, highlights to a consumer that there may be some harm in accessing the record, makes the judgment that it is, on balance, safe to provide information to a patient, but

then some harm occurs to the patient, or other people, as a result of that information being provided under the Act.

Another question focused on the situation in terms of indemnification when a health service provider refuses to provide information to a patient, but then the information is provided to the patient under some other process. If harm is thereby occasioned to the patient, or another person, as a result the health care provider who made the note might be exposed to liability.

Other issues

At the meeting with the meeting with the OFPC, significant discussion also occurred regarding the problems associated with media releasing details of the diagnosis and treatment of mental health patients. Mr Crompton agreed that this was of great concern to him, but pointed out that due to negotiations prior to the Privacy Act becoming Law, the media and politicians were made exempt. As a result, there was little that the Commissioner could do to change this. Mr Crompton was interested in the MHPC providing to his office any evidence it may collect about the harms resulting from exemption of the media. There was also some discussion around the fact that there are no guidelines, or determinations, regarding the use of health care information and the lack of access rules for electronic health records.

Way Forward

Dr White then reported that Mr Crompton acknowledged the concerns detailed above and asked the MHPC to develop a process in which the OFPC might participate to address these concerns. It was suggested that the process be discussed at a subsequent teleconference with the OFPC. Mr Crompton suggested that the way forward might be an educative process of the kind undertaken by the AMA and the Pharmacy Guild. He was reluctant to agree to suggestions that the Guidelines should be changed. Following further discussion it was agreed that it would be important to:

1. identify and particularize the concerns;
2. identify which concerns can be resolved under the current legislative scheme and which ones cannot and why;
3. identify a process for the concerns that can be resolved;
4. seek the Privacy Commissioners views on how unresolvable concerns can best be addressed; and
5. discuss the dissemination of educative materials.

Dr White indicated that the SPGPPS Secretariat was co–ordinating a subsequent MHPC Workshop, which would be held on Thursday, 27 June in Canberra. Hospitals advised that Ms Christine Gee, Chief Executive Officer, Toowong Private Hospital, will replace Mr Bernard McNair at the Workshop. The RANZCP advised that Dr Michael Honnery would replace Dr Yvonne White at the Workshop. There was a consensus that the Workshop would need to tackle some difficult issues and the SPGPPS noted that the Workshop Discussions would be held “in committee”.

1.4.2 AHMAC NATIONAL MENTAL HEALTH WORKING GROUP (NMHWG)

The Secretariat advised that the Chair of the NMHWG had written to the Chair of the SPGPPS requesting a nominee to sit on the NMHWG. The SPGPPS noted that this matter had been considered by the Executive Officers of the SPGPPS and it had been decided that the Chair of the SPGPPS would represent the SPGPPS on the NMHWG. In situations where the SPGPPS Chair is unable to attend a meeting of the NMHWG, then the Deputy Chair would attend. Where the Chair and Deputy Chair were unable to attend, then the SPGPPS Executive Officer would attend. There was consensus that that representation on the NMHWG was a substantive achievement that recognised the SPGPPS as the peak body

representing private sector psychiatric services. The SPGPPS noted that the back–to–back meetings between the SPGPPS and the NMHWG would continue until the end of 2002, but these arrangements may not be necessary in 2003.

RESOLVED

1. *That the SPGPPS endorses the appointment of the Chair of the SPGPPS to the Australian Health Ministers' Advisory Council, National Mental Health Working Group (NMHWG).*
2. *That the SPGPPS directs that, if the Chair of the SPGPPS is unable to attend a meeting of the NMHWG, then the Deputy Chair shall attend as their proxy. Where the Chair and Deputy Chair are unable to attend, then the Executive Officer shall attend as their proxy.*

The SPGPPS noted that its Executive Officer, Mr Phillip Taylor, would attend the next meeting of the NMHWG to be held on Friday 14 June 2002. Mr Taylor requested that stakeholders forward any issues they might wish to have raised at the meeting to the Secretariat no later than Wednesday, 12 June 2002. The SPGPPS noted that the NMHWG had established a Secretariat and appointed Ms Lynn Magor–Blatch as the interim Executive Officer.

2. FINANCIAL AND OPERATIONAL MATTERS

2.1 FUTURE LEADERSHIP OF THE SPGPPS

At the request of the 26th Meeting of the SPGPPS, the Secretariat prepared a discussion paper titled, *Future Leadership Options for the SPGPPS: A Discussion Paper Prepared for SPGPPS Stakeholders, February 2002.* The discussion paper was prepared in consultation with the SPGPPS stakeholders and the then AMA Legal Consultant, Ms Jane Ferry. The discussion paper included proposed resolutions to facilitate amendment of the SPGPPS Operating Guidelines if the leadership arrangements for the SPGPPS were to change. The four proposed proposed models were:

1. RANZCP Chair and democratically elected Deputy Chair (status quo)
2. Rotating Chair and democratically elected Deputy Chair
3. Rotating Chair with a psychiatrist holding the Chair or Deputy Chair
4. Elected Chair and Deputy Chair

The 27th Meeting of the SPGPPS noted the discussion paper and directed that this matter be deferred to 28th meeting of the SPGPPS.

Discussion

The SPGPPS then considered a copy of the discussion paper and amended the second sentence of second paragraph, which appears under the heading Health Funds, to read as follows:

> *HFPCLG has strongly supported the position espoused by the ~~Mental Health Council of Australia~~ SPGPPS Carer Representative that:*

Following amendment, the SPGPPS Legal Counsel, Ms Jane Ferry, advised the meeting on the available options and the issues that needed to be taken into account in relation to the four models detailed above. Ms Ferry also reminded the SPGPPS that the term office for all organizations was two years and that in February 2002 stakeholders would be asked for the names of their nominees for the remaining year of the contract. Ms Ferry also advised that the *AMA Agreement for Services* for the SPGPPS would expire in February 2004. The SPGPPS would need to begin considering, early in 2003, what was to be the fate of the SPGPPS beyond February 2004. Ms Ferry suggested that the SPGPPS may wish to defer consideration of this Agenda Item until later this year, or early in 2003.

SPGPPS stakeholders then discussed the models and each of the stakeholders reiterated views previously expressed and documented in the discussion paper. Hospitals, however, raised the possibility of the SPGPPS electing an RANZCP representative to Chair the SPGPPS from a list of several nominees put forward by the College. The SPGPPS noted that this was a variation on Model 1, which was not explored in the current discussion paper. The RANZCP indicated it would not be prepared to support this variation of Model 1, given the substantial effort that already goes into selecting the Chair for the SPGPPS.

The Carer representative, Mr John McGrath, requested that it be noted that the current debate concerning the future leadership of the SPGPPS did not reflect a lack of confidence in the current Chair.

Following further discussion, the SPGPPS decided that the following motion should be put to a vote of Representative Members by secret ballot.

MOVED (Dr Rodney/Dr Pring)

That the SPGPPS endorses the current arrangements for leadership of the SPGPPS whereby the chair is appointed by the Royal Australian and New Zealand College of Psychiatrists (RANZCP) and the Deputy Chair is appointed by a majority of the Representative Members.

The SPGPPS noted that the Deputy Chair had previously been appointed by a majority of the Representative Members at an earlier meeting, and there was no need to hold another election for the position of Deputy Chair.

The result of the secret ballot was a tied vote, five for and five against.

Ms Ferry advised that, Clause 17.2 of the SPGPPS Operating Guidelines states:

> *Each Representative Member present at a meeting of the SPGPPS, or of any Sub–Committee appointed by the SPGPPS, is entitled to one vote but, in the event of an equality of votes on any question, the person presiding over the meeting may exercise a second or casting vote.*

Ms Ferry advised that the Guidelines did not bind the Chair to exercising a casting vote. The Chair may decide not to do so and to announce that the motion had not been carried. Ms Ferry advised that the meeting could move to consider the other models, but may end up with a circular result. Alternatively, the matter could be left on the table for further discussion at a later time. In accordance with the rules of debate, the meeting should then proceed to its next item of business, leaving the leadership as is, at least for this meeting.

The Chair, Dr Yvonne White, declined to exercise a casting vote.

The motion was declared **NOT CARRIED**.

The meeting agreed that the motion should be put to the vote again at the 29th Meeting of the SPGPPS. Whilst the Guidelines indicate that persons should be present at meetings to cast their vote, Ms Ferry stated that there was no impediment to voting Members of the SPGPPS giving notice in writing to the SPGPPS Executive Officer of appointment of an alternates or proxies before the time of the 29th Meeting, which would convey voting rights to the alternate or proxies.

RESOLVED

1. *That the SPGPPS requests that the following motion be put to the 29th Meeting of the SPGPPS to be held on 27 September 2002 in Perth.*

   "That the SPGPPS endorses the current arrangements for leadership of the SPGPPS whereby the chair is appointed by the Royal Australian and New Zealand College of Psychiatrists (RANZCP) and the Deputy Chair is appointed by a majority of the Representative Members."

2. *That the SPGPPS directs that its Representative (voting) Members ensure*

the SPGPPS Executive Officer is informed, in writing, of the appointment of alternates or proxies no later than 5 PM on Tuesday 24 September 2002.

2.2 AMENDMENT OF THE SPGPPS OPERATING GUIDELINES

The SPGPPS then considered a copy of the SPGPPS Operating Guidelines with a view to whether any amendments were necessary.

It was agreed that the Guidelines should be amended, in light of the winding down of the Network of Australian Consumer Advisory Groups, NOAC and the establishment of the National Network of Private Psychiatric Sector Consumers and Carers (NNPPSCC). The amendments should acknowledge the existence of the NNPPSCC and enable the SPGPPS to obtain consumer and carer representation through either the NNPPSCC, or the MHCA. Should either of these organizations be unable to nominate, then the discretion of the SPGPPS to appoint appropriate individuals, should be retained in the Guidelines.

RESOLVED

That the SPGPPS requests that the SPGPPS Operating Guidelines be amended to remove all references to the Network of Australian Consumer Advisory Groups (NOAC) and acknowledge the establishment of the National Network of Private Psychiatric Sector Consumers and Carers (NNPPSCC). The amendments should be worded to enable the SPGPPS to obtain consumer and carer representation through either the NNPPSCC or the Mental Health Council of Australia. Should either body be unable to nominate, then the discretion of the SPGPPS to appoint appropriate individuals should be retained in the Guidelines.

2.3 SPGPPS DATA COLLECTION AND ANALYSIS PROJECT

The SPGPPS Data Collection and Analysis Project aims to put in place systems for the routine collection of data that will enable the relative effectiveness of various models of service delivery in the provision of mental health care services in private hospitals to be determined. The Project also aims to simplify overall hospital data collection requirements. Stage One of this Project was completed in May 2000 with the publication of the report titled: *A National Model for the Collection and Analysis of a Minimum Data Set with Outcome Measures for Private Psychiatric Services*.

Stage Two of this project involves the implementation of the National Model. In this Stage, Hospitals are asked to collect two standardised measures of clinical status, one clinician completed rating scale and one patient–completed questionnaire, at admission and discharge from episodes of overnight inpatient care, and at admission and discharge from episodes of ambulatory care. Where episodes of care are extended, Hospitals are also asked to collect the two measures at regular, 13 week, review intervals. Together with data collected under the Hospital Casemix Protocol (HCP), the information regarding patient's clinical status will be used in the generation of aggregate statistics regarding Hospitals' workload (casemix) and the outcomes of care of the care provided. The data collected by Hospitals is then submitted to the SPGPPS's Centralised Data Management Service (CDMS) in a de–identified format (maintaining compliance with the provisions of the Privacy Act). The CDMS will then provide Hospitals and Health Funds with reports for the evaluation and benchmarking of the services provided.

The SPGPPS then considered and noted the 3rd Progress report on implementation prepared by the SPGPPS Information Officer, Mr Allen Morris–Yates, which had been circulated with the agenda and papers for the meeting.

Discussion

Mr Morris–Yates spoke to the report and the SPGPPS noted that a second round of visits to each of the 37 participating Hospitals had been conducted in April 2002, for two purposes.

Firstly, to work through with key Hospital staff the processes for the import of HCP data and subsequent submission of both outcomes and HCP data to the CDMS. Secondly, to discuss and document any problems or issues which may have arisen, and review each Hospital's implementation of the requirements of the National Model.

Mr Morris Yates reported that the current status of implementation of the SPGPPS National Model by Hospitals was as follows.

		AT JULY 2001		AT MAY 2002	
Data Collection		**Of 37 Hospitals**	**Of 1525 Beds**	**Of 37 Hospitals**	**Of 1525 Beds**
HoNOS:	In–patient Care	92%	96%	92%	98%
	Ambulatory Care	–	–	54%	68%
SF–14–M	In–patient Care	54%	63%	70%	74%
	Ambulatory Care	–	–	38%	49%
Data Entry					
From or before February 2002		–	–	43%	46%
From or before May 2002		–	–	92%	90%
Using HSMdb software		0%	0%	92%	88%

Mr Morris–Yates reported that only one Hospital reported any problems with the actual ascertainment of the two standardised measures. In inpatient settings, the HoNOS was almost always being completed by nursing staff. Patients were generally found to have few problems completing the SF–14–M, with Hospitals reporting very low refusal rates. In the one hospital, which did report significant problems these were clearly related to the very negative attitudes held by a number of key senior nursing staff.

The SPGPPS noted that whilst Hospitals reported few problems with the use of the measures, quite a number were struggling with the implementation of the data collection process. The causes of these problems included:

- Poor understanding of the rationale for and requirements of the National Model by senior management.
- High usage of agency nursing staff associated with the inability to employ permanent staff.
- High staff turnover resulting in loss of momentum in the implementation process and understanding of the data collection requirements and process.
- Lack of basic IT support for software installation.
- Insufficient administrative resources devoted to the support of the data collection and entry process.
- Failure to identify and resource a key individual with responsibility for implementation of the data collection.
- Inadequate or incomplete training of staff.

Mr Morris Yates explained that the distribution of these problems was not related to the location of the Hospital, the size of the Hospital (in terms of the number of beds) or to size of their parent organisation. Active support and attention from senior management, the presence of a key person with a genuine interest in taking responsibility for the implementation (often the quality improvement coordinator or health information manager), and the provision of adequate administrative support were found to be critical factors in the successful implementation of the National Model.

The SPGPPS noted that the request for data for the first quarter of 2002 had been made to Hospitals and that the first National Report will be submitted to Hospitals and Health Funds in late July 2002. Mr Morris–Yates expected that for the 1st quarter of 2002, about one third of Hospitals will be able to submit relatively complete data of good quality, one half will submit a moderate amount of data of patchy quality, whilst the remainder will be able to submit very little data.

The SPGPPS believed that the second visit by Mr Morris–Yates in April was necessary and timely and should result in the data from second quarter of 2002 being more complete. Mr Morris–Yates anticipated that the first National Report will significantly raise the level of awareness among Hospital managers and their senior staff of the importance of their participation in the National Model.

In summary, Mr Morris–Yates indicated that it was important to recognise the way in which the participating Hospitals are leading the way with the implementation of outcome measures for psychiatric services in Australia. Shortly, the CDMS will provide Hospitals and Health Funds with the first National report, which is the first time such a Report would have been produced in Australia. Mr Morris–Yates indicated that this highly significant achievement carried with it very significant responsibilities for the SPGPPS and, in particular, Hospitals and Health Funds.

The SPGPPS acknowledged that this will be the first time such information will be in the public domain and that there is a substantial risk that the data will be misunderstood and misinterpreted. In this early stage, it will be particularly important that preliminary reports are **not** used for the purpose of interpretation, or any other inappropriate purpose. Hospitals are still learning how to reliably collect the data and this process will take around eighteen months or so. The SPGPPS agreed that an educational approach was required for at least the next 18 months.

The SPGPPS asked that a note of thanks be recorded to Mr Morris–Yates and the staff of the SPGPPS Secretariat, for the professional and understanding manner in which the implementation of the National Model had been undertaken.

RESOLVED

1. *That the SPGPPS notes Progress Report 3 on the implementation of the SPGPPS National Model for the Collection and Analysis of a Minimum Data Set with Outcome Measures for Private Psychiatric Services, prepared by the SPGPPS Information Officer, Mr Allen Morris–Yates.*
2. *That the SPGPPS directs that the Progress Report be made available on the SPGPPS Website at: www. spgpps.com.*
3. *That the SPGPPS advises that a co–operative educational approach be undertaken, over the next eighteen months, toward the reporting phase of the implementation of the National Model for the Collection and Analysis of a Minimum Data Set with Outcome Measures for Private Psychiatric Services.*
4. *The SPGPPS thanks Mr Morris–Yates and the staff of the SPGPPS Secretariat, for the professional manner in which the implementation of the National Model had been undertaken.*

The SPGPPS noted that the AHMAC NMHWG, Information Strategy Committee would be holding a three–day training workshop from the 23–26 June. Mr Morris–Yates would be presenting and participating in the workshop. The purpose was to start to upskill the public sector in training requirements for the collection of outcome measures nationally.

2.4 SPGPPS NATIONAL FORUM 2002

The SPGPPS National Forum 2002 will be held on Friday, 16 August 2002 at the Melbourne Airport Hilton Hotel. The Forum Flyer was distributed following the last meeting of the SPGPPS and, to date, 20 Delegates have registered to attend the Forum.

National Forum Agenda Committee

An *SPGPPS National Forum 2002 Agenda Committee* (NFAC) is overseeing the development of the program and resource material for the Forum. The committee is composed as follows.

- Chair SPGPPS Forum Dr Jonathan Phillips
- Chair SPGPPS Dr Yvonne White
- Consumer Ms Janne McMahon
- Hospitals Mr Tony Wallace
- Health Funds Mr Bruce Houghton
- SPGPPS Secretariat Mr Phillip Taylor, Mr Allen Morris–Yates

Other personnel who the SPGPPS have contracted to assist with Forum are as follows.

- Technical Advisor Mr Bill Buckingham (Template Development Adviser)
- Expert Advisor Prof Harvey Whiteford (Summary Paper and Keynote Address)
- Forum Facilitator Ms Lynette Glendinning (PALM Management)

Discussion

The SPGPPS noted that the first meeting of NFAC was held at the Stamford Sydney Airport Hotel on Tuesday, 4 June 2002. The purpose of the meeting was to develop the Forum Program, and secondly, to design a template to assist stakeholders with the development of Background Papers for the Forum. These Papers will form the basis of a *Summary Paper* that will be prepared by Professor Harvey Whiteford, Kratzmann Chair of Psychiatry, University of Queensland. The Summary Paper will draw together the key issues identified in the Background Papers and be presented on the day of the Forum.

A copy of the draft template developed by NFAC was then tabled and considered by the meeting.

Consumers and Carers expressed concern over the strong focus on funding models in the draft template and the difficulties they would face preparing their Background Papers unless there was stronger emphasis on innovative service delivery models in the first instance.

Mr Morris–Yates explained that, at the NFAC meeting, there was a very strong feeling that innovative models of service delivery cannot be put in place, unless funding mechanisms to support that innovation are in place first. Part of the reason that the comprehensive models of care, that are needed have not been developed, is because of the current limitations in funding arrangements.

The RACGP felt, however, that this was in effect putting the "cart before the horse". The agreed topic for the Forum had been *Innovative Models of Service Delivery and Funding* and this had been based on the view that the innovation in service delivery must come first and then the issue of funding. The RACGP indicated that there needed to be an emphasis on innovative models of service delivery, in the first instance, and then the questions on funding were well placed to follow. Consumers and Carers indicated that this approach would make their task easier.

The RANZCP supported this view and indicated that, while funding models were a central issue, innovation in service delivery needed to be addressed. The RANZCP also felt strongly that training was inextricably linked to service delivery and funding. Health Funds and Hospitals also felt the training issues were highly relevant to the private sector.

There was unanimous agreement that the concerns of the meeting could be addressed if Question 1 in the template drew attention to innovative models of service delivery and

training. Questions 2 and 3 could then remain the same. Questions 4 and 5 should then be amended to include reference to models of service delivery and funding. The draft template was therefore amended as follows.

1. What goals would your stakeholder group have in developing ~~new funding~~ innovative models of service delivery and training?

   Try to be specific about the types of benefits you would like to see and for whom.

2. What aspects of current funding arrangements limit the achievement of these goals?

   Describe, for example, legislative barriers, range of benefits, multiplicity of funders etc.

3. What practical changes need to be made to achieve the goals identified above:

   - in the short–term; and
   - in the long–term?

   If possible, include examples drawn from mental health, or other areas, to illustrate the type of changes proposed.

4. What are the risks for your stakeholder group in pursuing innovative models of service delivery and new funding arrangements, and what safeguards should be put in place to minimise these?

5. What next steps should be taken in developing innovative models of service delivery and funding models in the private sector?

The meeting then endorsed the draft template as amended by the SPGPPS.

The SPGPPS noted that the following nominees would be responsible for the Background Paper development over the next three weeks or so.

Stakeholder Group	**Author(s) or Person(s) Responsible**
Hospitals	Mr Ashley Cooper
Health Funds	Mrs Judy Hardy
Psychiatrists	Dr Bill Pring
GPs	Dr Brian Kable
Consumers & Carers	Ms Janne McMahon, Ms Alvina Hill, Mr John McGrath, Mrs Ruth Carson
Commonwealth	Mr Mick O'Hara and Mr Peter Callanan

The SPGPPS also noted that the timeframe for the development of the Forum Background Papers was as follows.

Deadlines	**Tasks**	**Status**
Wednesday 12 June	Circulation of Background Paper Template	✓ Pending
June – July	Background Paper Development (1000 – 2000 words)	✓ Pending
Monday, 8 July	Final Background Papers to SPGPPS Secretariat.	✓ Pending
Tuesday, 9 July	Background Papers to Prof. Harvey Whiteford	✓ Pending
Friday, 2 August	Final Summary Paper to SPGPPS Secretariat	✓ Pending
Wednesday, 7 August	National Forum Folders Circulated	✓ Pending

It was noted that the draft program for the Forum had also been finalized by NFAC and would be circulated shortly.

The SPGPPS then appointed nominees to facilitate Small Group Sessions on the day of the Forum, in consultation with Ms Lynette Glendinning. The meeting considered the anticipated number of Delegates and the size of the Small Group Sessions. While five Small Groups of 20 Delegates was considered a little large, the meeting agreed that the structure of the Forum should enable the major key issues to be addressed and a way forward determined. It was further agreed that there may be a need for an extra Small Group Session should more than 100 Delegates register for the Forum.

RESOLVED

1. *That the SPGPPS endorses the SPGPPS National Forum 2002 Template, as amended, to assist SPGPPS stakeholders (Hospitals, Health Funds, Psychiatrists, GPs, Commonwealth and Consumers and Carers) in the development of background papers for the Forum.*
2. *The SPGPPS requests the Secretariat to circulate the SPGPPS National Forum 2002 Template to the nominees responsible for the development of Background Papers for the SPGPPS National Forum 2002.*
3. *That the SPGPPS appoints the following nominees as facilitators for Small Group Sessions at the SPGPPS National Forum 2002.*

Small Group Session 1: Mrs Moira Munro
Small Group Session 2: Dr Bill Pring
Small Group Session 3: Mrs Judy Hardy
Small Group Session 4: Dr Brian Kable
Small Group Session 5: Dr Jo Lammersma
Small Group Session 6: Mr John McGrath (If a sixth small group is necessary)

2.5 MENTAL HEALTH COUNCIL OF AUSTRALIA (MHCA) SERVICE AGREEMENT

The 27th meeting of the SPGPPS agreed to contribute a one third share of up to $2750 to enable one consumer and one carer from the private sector to participate on the AHMAC National Consumer and Carer Forum (NCCF). At that time, the contribution was to be made in partnership with Health Funds and Hospitals in accordance with the following schedule and conditions.

Schedule of Contributions 2002

Health Funds	$2750
Hospitals	$2750
SPGPPS	$2750
Total	$8250

Conditions

1. The SPGPPS, Health Funds and Hospitals have the opportunity to consider and endorse the individuals nominated to represent the interests of private sector consumers and carers on NCCF.
2. The SPGPPS, Health Funds and Hospitals are provided with a joint written report following each NCCF, which includes:
   - a summary of areas and issues covered pertinent to the private sector; and
   - feedback on difficulties, issues and initiatives concerning the improvement of care in private sector mental health services.

The 27th Meeting of the SPGPPS also acknowledged that it would be necessary to provide **interim** representation at the first NCCF (April 15/16 2002) until the funding arrangements, detailed above, could be confirmed and finalised. Ms Alvina Hill and Ms Ruth Carson attended and their report appears under Agenda Item 3.1. The MHCA subsequently funded these two representatives on the basis that costs involved would be recovered when the MHCA Service Agreement was in place and the invoice for $8250 was paid by the SPGPPS for and on behalf of SPGPPS, Hospitals and Health Funds.

Discussion

The Chair reported that, since the 27th meeting, there had been a number of developments. Firstly, written confirmation had been received from the APHA concerning the arrangements detailed above. No response had been received from the AHIA. Secondly, the MHCA had

forwarded a Service Agreement between the SPGPPS and the MHCA, to the SPGPPS Secretariat, together with an invoice for $8250.

The Service Agreement, and invoice had been considered at the 21 May 2002 SPGPPS teleconference. The teleconference advised that the MHCA Service Agreement should be further developed to better reflect and protect the tripartite nature of the financial arrangement between the SPGPPS, APHA and the AHIA. There was also some discussion around the issue of whether the full amount ($8,250) should be directed toward the NCCF, or whether some of the funding should go toward the newly established NNPPSCC for teleconferences and other supportive activities. The teleconference agreed that this matter required further careful consideration at this meeting of the SPGPPS. In the interim, the Secretariat and the SPGPPS Legal Counsel, Ms Jane Ferry, were asked to prepare a revised version of the MHCA Agreement based on these developments.

A copy of the revised Service Agreement between the MHCA, SPGPPS, APHA and AHIA was tabled and Ms Ferry explained the content of the Agreement.

In considering the revised Agreement, the meeting discussed the role and future of the NNPPSCC. Consumers and Hospitals indicated that the NNPPSCC had the potential to become the definitive organisation representing the interests of private sector mental health consumers and their carers. If properly supported and funded, the organization could provide nominees to the SPGPPS and any other bodies that might seek consumer and carer representation from the private psychiatric sector. It would also be able to apply for membership of the MHCA in its own right.

The Chair pointed out that, should the SPGPPS decide to change the funding originally agreed to, then there was a risk that the private sector would forfeit its representation on the NCCF. Consumers acknowledged that risk, but felt it was more important for private sector to continue to pursue its own representational structure. On that basis, Consumers felt strongly that the SPGPPS should revisit its decision to fund private sector representation on the NCCF and redirect any remaining funding toward the NNPPSCC.

The SPGPPS agreed that this matter needed to be resolved by this meeting and acknowledged that there were two key issues involved. Firstly, it is critical that the private sector have its own consumer and carer organization. Secondly, there is a need for private sector mental health consumers and carers to be represented on all relevant national bodies.

Hospitals reported that they supported **both,** the critical need to fund the fledgling NNPPSCC, **and** the need ensure the private sector is represented on national consumer and carer bodies such as the NCCF. The SPGPPS noted that the APHA psychiatric Sub–committee currently supported the tripartite funding arrangement for private sector consumer and carer representation on the NCCF and were looking at the issue of funding for NNPPSCC.

Health Funds acknowledged these developments and felt that the original SPGPPS decision should be revisited. The AMA felt that the primary focus should be to foster the development of the NNPPSCC. Carers supported this position, and suggested that SPGPPS financial stakeholders should seriously consider providing funding to foster the development of the NNPPSCC. The Secretariat pointed out that stakeholders would require an estimate of how much funding would be required and it was agreed that those costs should be investigated. The requirements of the formal processes involved for the NNPPSCC to become a member organization of the MHCA were also discussed and Hospitals reported that they would be assisting the NNPPSCC with its application shortly.

In light of these deliberations, the meeting decided to revisit the SPGPPS decision to fund private sector representation on the NCCF. It was agreed that the SPGPPS would decline the provision of any further funding for private sector consumer and carer representation on NCCF.

On that basis, the SPGPPS further agreed to reimburse the MHCA for the costs associated with the attendance of the private sector consumer and carer representatives at the April 15/16 NCCF held in Canberra. The SPGPPS would then invoice the APHA and the AHIA for their one–third share of these costs.

The SPGPPS then asked its financial stakeholders to approach their constituent organizations and ascertain whether they would be willing to contribute funding to support the NNPPSCC. Ms Munro, Ms McMahon, and Mr Taylor were asked to investigate the approximate annual costs that would be involved to support the NNPPSCC in consultation with Mrs Hardy.

RESOLVED

1. *That the SPGPPS declines the provision of any further funding for private sector consumer and carer representation on the National Consumer and Carer Forum.*
2. *That the SPGPPS requests the Mental Health Council of Australia to invoice the SPGPPS for the costs associated with the attendance of the private sector consumer and carer representatives, at the first National Consumer and Carer Forum held on April 15/16 2002 in Canberra.*
3. *That the SPGPPS forward invoices to the Australian Health Insurance Association and the Australian Private Hospitals Association, for their one–third share of the costs associated with the attendance of private sector consumer and carer representatives, at the first National Consumer and Carer Forum held on April 15/16 2002 in Canberra.*
4. *That the SPGPPS requests that Ms Janne McMahon, Ms Moira Munro, and Mr Phillip Taylor, in consultation with Mrs Judy Hardy investigate and advise the SPGPPS on the approximate costs involved with sustaining the National Network of Private Psychiatric Sector Consumers and Carers.*
5. *That the SPGPPS requests that its financial stakeholders consider contributing funding to support the National Network of Private Psychiatric Sector Consumers and Carers (NNPPSCC). Alternative funding sources, such as the Commonwealth Consumer Focus Collaboration, should also be explored.*
6. *That the SPGPPS supports the intention of the National Network of Private Psychiatric Sector Consumers and Carers to seek membership of the Mental Health Council of Australia.*

Ms Janne McMahon thanked SPGPPS stakeholders for their support of the NNPPSCC.

3. DISCUSSION ITEMS

3.1 FIRST NATIONAL CONSUMER AND CARER FORUM (NCCF)

The 27th Meeting of the SPGPPS acknowledged that it would be necessary to provide interim representation at the First NCCF, held on April 15/16 2002. Ms Alvina Hill (consumer) and Ms Ruth Carson (carer) agreed to represent the interests of private sector at the April NCCF as interim representatives.

RESOLVED

That the SPGPPS notes the Report to the SPGPPS on the First Annual National Consumer and Carer Forum 15–16 April 2002, prepared by the interim private sector consumer and carer representatives on the Mental Health Council of Australia's (MHCA) National Consumer and Carer Forum (NCCF), Ms Alvina Hill (consumer) and Mrs Ruth Carson (carer).

3.2 GUIDELINES FOR DETERMINING BENEFITS FOR HEALTH INSURANCE PURPOSES FOR PRIVATE PATIENT HOSPITAL–BASED PSYCHIATRIC CARE

The 26th Meeting of the SPGPPS established a working group to participate in reviewing these Guidelines. The Working Group met via teleconference on Monday, 12 February 2002 and revised the Guidelines in accordance with the feedback received from the private sector. The 27th Meeting of the SPGPPS noted the revisions to the Guidelines, prepared by the SPGPPS Working Group and requested that the relevant stakeholders discuss the revisions with their constituencies, with a view to a final version of the Guidelines being prepared for endorsement by the 28th meeting of the SPGPPS.

Discussion

The final version of the Guidelines were considered and endorsed by the meeting, following minor amendment to further clarify the use of the term *mental illness*.

RESOLVED

That the SPGPPS endorses the Guidelines for Determining Benefits for Health Insurance Purposes for Private Patient Hospital–Based Psychiatric Care, as amended by the 28th Meeting of the SPGPPS requested that the Commonwealth Department of Health and Ageing, Private Health Industry Branch, take the necessary steps to ensure the revised Guidelines are implemented.

3.3 TRANSFER OF ACCREDITATION STATUS

Mr Brian Johnston, Chief Executive Officer of ACHS, attended the meeting to discuss the concerns of Health Funds concerning transfer of accreditation status. Health Funds require accreditation (or proof of a booked survey) by a recognised external agency (most choose ACHS), for a hospital to receive payment of benefits. Health Funds recognise the costs involved with this process, and the effort involved in commitment to a process of quality improvement required to obtain and maintain accreditation. The following ACHS actions have, therefore, been of considerable concern to Health Funds.

1. The reinstatement of full accreditation to a hospital following closure, change in ownership, re–opening at a later date with new programs and program staff.
2. The granting of a continuation of accreditation to a hospital, previously used as a surgical hospital. This hospital is leased by a large group that has expertise in the running of psychiatric hospitals. However, staffing and program structures are still to be finalised.

Discussion

Both of the situations described above were considered. Mr Johnston responded that the ACHS was aware of the concerns of Health Funds and had responded in writing concerning the first situation. Mr Johnston denied knowledge of the second situation and indicated that the Hospital concerned was not actually accredited by the ACHS.

Mr Johnston then explained that ACHS, as a rule, does not simply transfer accreditation. Even where there is a change in ownership and a Hospital indicates it intends to continue with its previous role, accreditation is still not automatically transferred. Mr Johnston explained that there are a series of issues that must be addressed by the ACHS in consultation with the new owners of a Hospital some of which include the following.

- Who are the new owners?
- Are the new owners committed to the accreditation process?
- Are there any significant changes in staff?
- Are there any changes to the nature of the building structures?
- Are there any changes to the State and Territory licensing conditions?
- Is there any refocus of the clinical directions and activities of the facility concerned?

Mr Johnston indicated that these issues are considered on a case–by–case basis, and particular attention is given to situations where a Hospital intends to refocus the services it provides. Where there are concerns, the ACHS has mechanisms in place to ensure that accreditation is not automatically transferred.

Health Funds indicated that some corporate groups that own private hospitals had now become so large and diversified that Health Funds had serious concerns over the capacity of some of these Hospitals to meet accreditation against the National Standards for Mental Health Services (hereafter National Standards). This is of particular concern given that Health Funds have supported the SPGPPS policy position of applicability of the National Standards for private psychiatric hospitals. Further, some Health Funds have also placed Hospitals on notice that it is expected that future full surveys will be against the in–depth National Standards. Health Funds indicated that, to date, no private sector facilities have applied for accreditation against the National Standards. Hospitals responded and indicated that the majority of private hospitals with psychiatric beds have been accredited by the ACHS since the mid–to–late 1980s.

Hospitals indicated that, currently, facilities are accredited by the ACHS using the EQuIP model and, that under that model, there is nothing that prevents a Hospital being accredited provided it meets the EQuIP safety standards. The ACHS explained that EQuIP is a generic framework for hospital management directed towards safety and quality improvement. It is then for the organization to apply it within any given facilities context. As such, EQuIP is not a clinical governance model. Hospitals explained that there is now provision for the introduction of accreditation by the ACHS using the National Standards. This will provide specific accreditation for mental health services provided by a Hospital. It was anticipated that most Hospitals providing mental health services would seek accreditation against the National Standards. At present the ACHS is the only organization able to accredit Hospitals against the National Standards. Until such time, however, as there are other organizations capable of providing this service, under current legislation Health Funds may not require Hospitals to be accredited against the National Standards.

The ACHS then provided an overview of how it will meet the anticipated demand for accreditation using the National Standards from both the public and the private sector. This raised concerns over the current difficulties involved with the recruitment of consumers and carers and the particular implications for the private sector. Hospitals indicated that the APHA Psychiatric Sub–committee had raised this issue with the ACHS at a recent meeting. The Sub–committee was particularly concerned about the recruitment of *appropriate* consumer surveyors that actually had private hospital experience. Mr Johnston responded and stated that these issues have been dealt with by the ACHS. Mr McGrath spoke about the history of this issue and the recent MHCA developments that should operate to improve the training opportunities for consumers and carers in the future.

Mr Johnston clarified several other issues for the Consumer representative, Ms Janne McMahon. The SPGPPS thanked Mr Johnston for his presentation.

3.4 REVIEW OF THE REGULATORY FRAMEWORK FOR PRIVATE HEALTH INSURANCE FUNDS

The *Review of the regulatory framework for private health insurance funds* is intended to build on the work of an interdepartmental working group, which is advising the Government on issues around the current regulatory framework for private health insurance. The CDHA, has written to peak bodies informing them that any views they might have about the current regulatory arrangements would be most welcome. In particular, proposals for regulatory

reform aimed at enabling consumers to receive the best value for money for their insurance will be considered. The private health industry is currently being consulted on a range of private health regulatory and service delivery issues including:

- current prostheses funding arrangements;
- revisions made to 2nd Tier arrangements in 2001;
- the new capital adequacy and solvency standards introduced in 2001;
- access to private hospitals by privately insured patients;
- funding and service delivery for private sector sub–acute care and care of older people including rehabilitation funding and classification arrangements;
- the role of the Acute Care Advisory Committee;
- the provision of overseas student health cover; and
- possible reform of existing re–insurance arrangements.

The SPGPPS noted that Mr Bob Wells, First Assistant Secretary, Health Industry and Investment Division, was nominated to discuss issues related to the review. The Minister expects to receive advice on the review by the middle of this year and the official deadline for input was 10th May 2002.

Discussion

The Chair reported that the SPGPPS has responded to the review by briefing Mr Wells and providing background material of SPGPPS previous deliberations in this area. Mr Wells has indicated that he would be happy to receive, further input from the SPGPPS into the review process. The SPGPPS noted that a copy of the AMA submission to the Review had been circulated to the SPGPPS.

Mr Callanan reported that there were a number of fundamental issues that the internal review was trying to come to terms with and that it was not clear whether there would be an opportunity to comment on the final report to the Minister.

In response to the review, the SPGPPS Consumer representative indicated that it was important for the Lifetime community rating to remain in legislation to protect consumers with whole of life (chronic) illnesses who access hospital/outreach services. Consumers are also concerned about the lack of clear information and the complexities of the products offered by individual Health Funds.

It was felt that, where possible, SPGPPS stakeholder organizations should forward copies of their submissions to the Secretariat for circulation to the SPGPPS.

The SPGPPS Secretariat was also asked to prepare another brief follow–up submission to the review detailing issues and concerns expressed at this meeting, as examples of current practices.

RESOLVED

That the SPGPPS requests that, where possible, SPGPPS stakeholders organisations forward to the SPGPPS Secretariat their submissions to the Review of the regulatory framework for private health insurance funds for circulation to the wider SPGPPS.

That the SPGPPS Secretariat prepare a brief follow–up submission to the Review of the regulatory framework for private health insurance funds detailing issues and concerns expressed at the 28th meeting of the SPGPPS. The submission should provide examples of any current practices that might disadvantage consumers of mental health services in the private sector.

3.5 ELECTRO–CONVULSIVE THERAPY (ECT)

The Committee for Psychotropic Drugs and Other Physical Treatments of the RANZCP has considered the problem of restricted health insurance rebates for patients undergoing ECT, and referred this matter to the SPGPPS for examination. According to the Committee, it appears that many (if not all) Health Funds restrict the number of ECT treatment rebates to twelve in any twelve months. After 12 treatments, the patient is not reimbursed by the Health Fund for the hospital charges associated with the treatments. Depending on the nature of the agreement between an individual private hospital and a particular Health Fund, this may mean either that the hospital is unable to charge an appropriate fee for the service it provides, or that the patient faces a significant "gap" payment, if more than 12 treatments are required during one year.

The Committee has indicated that many patients require more than 12 ECT treatments in one year. At one large treatment facility it is estimated that 20% of patients fall into this category. Relapse and recurrence following ECT continues to be a significant clinical problem, affecting 50 % – 60% of patients who respond to ECT, despite maintenance medication. This has led to the increasing use of continuation and maintenance ECT. Patients on a maintenance ECT programme are likely to need between 20 and 30 treatments in the twelve months following an acute course. Many who are not having maintenance ECT will require a second or third course of ECT during that 12 months in order to treat relapse and recurrence of their illness. It is, therefore, clear that limiting rebates to 12 treatments per year does not reflect standard clinical practice.

The RANZCP is concerned that some hospitals may either, not establish a quality ECT service, or, may cease providing an existing service because of their inability to charge an appropriate service fee. Alternatively, an unfair financial burden falls on a select patient group if costs are passed to the patient, together with the perception that this practice discriminates against the mentally ill and psychiatric treatment.

Discussion

In examining this matter, the SPGPPS considered the historical basis to limitations that had been placed on ECT and the nature of this clinical intervention. It was noted that this treatment is not given lightly and that its use has changed over time. Today, ECT is usually reserved for the treatment of severely mentally ill people. Consumers believed that ECT had proven a cost effective form of treatment that enabled consumers to be maintained effectively outside of the in–patient Hospital setting.

The RANZCP agreed to provide a document, which describes current evidence–based best practice for the provision of ECT. The SPGPPS agreed to then write to the CDHA requesting that the necessary steps be taken to ensure that and Health Funds amend their respective rules to accord with current best practice in relation to ECT. A copy of the letter should be sent to the Health Fund Psychiatric Care Liaison Group.

RESOLVED

1. *The SPGPPS requests that the Royal Australian and New Zealand College of Psychiatrists provide to the SPGPPS Secretariat a document, which describes the current evidence–based best practice for the provision of Electro–convulsive Therapy.*
2. *That the SPGPPS write to the Commonwealth Department of Health and Aged Care concerning Electro–convulsive Therapy (ECT) and request that the necessary steps be taken to ensure that Health Funds amend their respective rules to accord with current best practice in relation to ECT, as defined by the Royal Australian and New Zealand College of Psychiatrists.*
3. *The SPGPPS requests that the issue of restriction of rebates for Electro–convulsive Therapy treatment be included in the SPGPPS submission to the Review of the regulatory framework for private health insurance funds, as an*

example of a current practice that disadvantages consumers of mental health services in the private sector.

3.6 STEP–DOWN FUNDING

Hospitals reported that that some health funds have reduced benefits payments for patients who are re–admitted to a private psychiatric facility with the same diagnosis in the same calendar year. This reduction in funding applies to *re–admission* of patients with an *acute episode* of the same diagnosis to a hospital setting, *not* to a designated step–down program.

Discussion

This issue was discussed and it was resolved.

RESOLVED

The SPGPPS requests that the issue of step down funding be included in the SPGPPS submission to the Review of the regulatory framework for private health insurance funds, as an example of a current practice that disadvantages consumers of mental health services in the private sector.

3.7 CO–PAYMENTS FOR DAY–ONLY PATIENTS

Hospitals and providers have expressed concern that Health Funds have applied limits to the number of days for which they will pay benefits for day programs. Health providers have expressed concerns over at least one Health Fund in Victoria that is applying a $50 co–payment to patients who are being treated in private Day–Only facilities.

Discussion

Hospitals and providers expressed concern over the impact this practice will have on chronically ill patients who have minimal income. Many chronically ill people will be unable to bear this cost and will have to seek treatment in the already overburdened public sector. Ultimately, this could result in Day–Only treatment becoming untenable in the private sector.

Health Funds reported that several Health Funds have received a number of complaints from providers concerning this issue.

RESOLVED

1. *The SPGPPS requests that the issue of restriction of co–payments for Day–Only Treatment funding be included in the SPGPPS submission to the Review of the regulatory framework for private health insurance funds, as an example of a current practice that disadvantages consumers of mental health services in the private sector.*
2. *The SPGPPS requests that the Secretariat organise a meeting with the Chronic Illness Alliance concerning restriction of co–payments for Day–Only Treatment funding.*

4. INFORMATION ITEMS

The following Information Items were noted en bloc as read and then updated by the meeting.

4.1 TELEPSYCHIATRY

Based on the results of the *Psychiatry Pilot Projects*, the 15 March 2002 meeting of the AHMAC NMHWG considered a proposal for a national trial of CMBS items for telepsychiatry in Queensland, South Australia and Victoria subject to:

- agreement between the Commonwealth and the RANZCP on the conditions to apply to the use of CMBS Items; and
- agreement within each of the three trial states on the arrangements to apply for infrastructure use and funding.

After discussion, the NMHWG decided to place telepsychiatry on the agenda for the 14 June 2002 meeting for further discussion and to progress certain actions in the period between the two NMHWG meetings.

The CDHA is considering the Working Group proposal in the context of the recent submission by the RANZCP in support of the practical implementation of telepsychiatry. This submission addresses the question of developing specific telepsychiatry CMBS items for, Case Conferencing, Consultation Substitution (Referred Consultation via Telepsychiatry) and Emergency Psychiatric (Participation in a Consultation–Liaison Telepsychiatric Session)

CDHA reported that the Medicare Benefits Branch of the Department is examining the RANZCP submission and will establish, in the near future, a Medicare Benefits Consultative Committee (MBCC) to more fully consider it. The MBCC membership will be drawn from the Department, the AMA and the RANZCP. The Department will be writing to the RANZCP shortly to invite the College to participate in the MBCC. The Department is unable to predict the outcome of the MBCC consultative process or to say if any, or all, of the College's proposal will be accepted or not accepted. The Department, however, would like to be able to make a final decision on telepsychiatry item numbers in time for the deadline for changes to the next edition of the CMBS, due for release in November 2002. The deadline for CMBS changes for the next edition is 1 August 2002.

4.2 SAFETY AND QUALITY IN MENTAL HEALTH

The SPGPPS is participating in a fledgling partnership between the RANZCP (QI Committee), MHCA, and the AHMAC NMHWG Safety and Quality Sub–committee (SQC) in order to strengthen the national agenda around safety and quality in mental health.

To date, the partnership has met twice including one face–to–face meeting in February 2002. The partnership has prioritised **safety** as the key issue to be addressed over the next few years and has undertaken some preliminary planning for a proposed bi–national symposium to examine some key indicators of safety.

A preliminary discussion paper outlining this proposal was put to the March 2002 meeting of the NMHWG. The NMHWG supported, 'in principle", the concept of a symposium at a future date. The NMHWG believed, however, that preliminary work needed to be done to scope what data is available and how it might best be used within the context of the broader mental health safety and quality agenda under the National Mental Health Strategy. That agenda currently includes:

- The National Standards for Mental Health Services
- State and Territory Information Development Plans (IDPs)
- Implementation and routine use of agreed outcome measures by 2003
- National Practice Standards for the Mental Health Workforce
- Clinical Practice Guidelines

The SPGPPS representative on the Partnership, Mr Phillip Taylor, reported that SQC is currently looking at developing a work plan, what resources it will require and linkages between the SQC, Workforce Development group(s), the NMHWG Information Strategy Committee (ISC) and the National Committee on Safety and Quality in Health Care. At this stage SQC has identified three key indicators for review.

1. Rates of Seclusion (incidents of adverse events associated with seclusion may be a possible subset).

2. Rates of Suicide/attempted Suicide (or serious self harm behaviours) whilst in care
3. Adverse events associated with psychotropic medications.

Mr Taylor indicated that a questionnaire has been developed as a first step to determining which public sector facilities might be interested in sharing information, to identify the types of data that are already being collected, and to highlight the range of innovations that may already be in place.

Completion of the questionnaire will be voluntary and an external consultant, Dr David Dean of Chappell Dean Pty Limited will assist with the collation and analysis of the survey responses.

A copy of the questionnaire will be forwarded to the SPGPPS shortly.

Mr Craig Patterson reported that the RANZCP will also meet shortly with representatives from the following organisations.

- The RANZCP QI Committee
- The Board of the Instititute of Clinical Effectiveness in New South Wales
- The Australian Council on Quality and Safety in Health Care
- National Institute for Clinical Studies
- La Trobe University

The purpose of the meeting will be to assess what is currently happening in quality and safety in mental health and what the next steps should be. Mr Patterson will report back to the SPGPPS on the outcome of this meeting.

4.3 SECOND TIER BENEFITS

The CDHAC Private Health Industry Branch undertook a review of the default table of benefits following consultation with the private health industry. The then Minister approved the recommendations from the review and a revised version of the second tier determination, under paragraph (bj) Schedule 1 of the *National Health Act 1953*, was gazetted on 20 July 2001. The revised second tier provisions, that took effect from 1 August 2001, aim to correct anomalies that existed in the original provisions.

The five main changes were:

- Improved quality of care criteria;
- Introduction of an Industry Second Tier Advisory Committee;
- Improved dispute resolution mechanism;
- A more clearly defined benefit calculation; and
- Increased transparency of benefit levels for hospitals.

As outlined in Commonwealth Circular HBF 721 PH 455 the Department of Health and Ageing is formally reviewing the revised second tier arrangements following the six–monthly update of second tier benefit schedules.

The aim of the review of the revised second tier arrangements is to improve, where necessary, the requirements within the revised arrangements. Primarily the review will assess:

- if there is any significant variation within funds' second tier benefits schedules following a 6–monthly update of their second tier benefit schedules at 1February 2001;
- the most appropriate timing for the updating of a funds' second tier benefits schedules whilst having regard to matters such as changes to contribution rates;
- the usefulness of the comparable hospital categories; and
- any other matter relating to the new second tier provisions.

The Department wrote to the private health insurance and the private hospital industry to invite submissions, with specific examples and supporting data, on how the second tier administrative arrangements could be further improved, particularly in regard to the issues raised above. Submissions were due by 30 April 2002.

The Department is now considering the submissions received from the industry to the second tier review. The outcome of the second tier review will be considered in the context of the broader private health insurance review when appropriate.

Full details of the new arrangements for the second tier benefit, including a copy of the schedule listing the eligibility criteria, are contained in the Commonwealth Department of Health and Ageing Circular HBF721/PH455. Copies of this circular are available at http://www.health.gov.au/privatehealth/providers/circulars01–02/index.htm.

4.4 CLINICAL CARE PATHWAYS

The RANZCP scoping exercise to explore the potential use of Clinical Care Pathways (CCPs) in psychiatry and mental health services was completed in 1999 and a project report was provided to the CDHA.

The report highlighted the lack of experience and information in applying CCPs across community care in mental health and identified that most work to date had focused on diagnostic related groups, particular events such as Electro convulsive Therapy, or events within a CCP such as assessment or admission. The report, however, did conclude that CCPs could promote quality patient care by incorporating standards and Clinical Practice Guidelines and providing a mechanism whereby care can be monitored on the basis of outcomes.

Mr Craig Patterson reported that the RANZCP has applied for funding from the Commonwealth to publish the report as a discussion paper for consideration and comment. The consultation process will be carried out by the RANZCP, and a report prepared for the Commonwealth within three months.

4.5 CLINICAL PRACTICE GUIDELINES PROJECT

In late 1998, the Commonwealth Department of Health and Ageing and the New Zealand Health Funding Authority provided funding for the Royal Australian and New Zealand College of Psychiatrists (RANZCP) to develop a series of evidence–based Clinical Practice Guidelines (CPGs) for clinicians and for consumers on Schizophrenia, Anorexia Nervosa, Deliberate Self Harm, Major Depression (in adults), Bipolar Disorder, and Panic Disorder and Agoraphobia.

This initiative was intended to result in a set of user friendly and accessible CPGs that could be used as a resource for clinical decision–making. The series would replace an earlier and now outdated Treatment Outline series. All available CPGs can be obtained from the College website: www.ranzcp.org.

The CPGs were originally being developed through a decentralised development process with six separate writing teams. A national Steering and Implementation Committee, was convened by the RANZCP, to oversee the CPG development process and the dissemination/implementation planning. The Steering Committee was comprised of representatives from consumers and carers, the CDHA Mental Health and Special Programs Branch, the SPGPPS, non–government consumer informatics, and medical education and implementation expertise.

Mr Craig Patterson reported that there have been significant changes to the CPG process and these changes are based on, and have been guided by, the principle that treatment decisions are determined by the combination of available evidence, clinician experience and patient

preference. Consequently the College will now produce CPGs that summarize the available evidence in each area.

Currently the teams for each disease guideline are producing the 6 summaries. A series of day–long workshops will then be held which will provide feedback and help produce the final document. These workshops will be chaired by an independent senior clinician who will have not had any previous input to the process. A broad range of people from all sections of the College will be invited including public and private sector psychiatrists and representatives from the Sections, Faculties and Special Interest Groups.

4.6 INTEGRATED NATIONAL MENTAL HEALTH SERVICE PROJECTS

The aim of these Projects is to establish and document approaches to integrating private psychiatric services and public sector mental health services. The purpose is to create and test a more flexible integrated framework within which mental health care can be delivered, and to optimise outcomes for consumers. The Projects are expected to achieve improvements in the quality, appropriateness, and efficiency of mental health service delivery by:

- assisting greater involvement of private psychiatrists in public sector mental health services;
- providing continuity of care for private psychiatrists' patients who require hospitalisation; and
- improving linkages with primary care, especially general practitioners.

Three projects, one in Victoria and two in New South Wales, are in a Live Phase, as set out below. The University of Wollongong's *Centre for Health Service Development* is providing technical advice and support to all projects.

- ***Victoria***

  The Public and Private Partnerships Project of inner East Melbourne is a joint initiative of St Vincent's Mental Health Services and the Melbourne Clinic. The project commenced in September 2000 after completing a lengthy 2–year planning phase. The evaluation team for this project is headed by Ms Jenni Livingston from the Centre for Health Program Evaluation, University of Melbourne.

- ***New South Wales***

  Two projects commenced the Live Phase on 1 July 2001.

  1. Far West Area Health Service – the project has involved extensive consultation with consumers and carers, Indigenous Australian groups, as well as other stakeholders, and offers the opportunity to trial various ways of improving psychiatric services in a remote rural setting.

  2. Illawarra Area Health Service – the project proposes an integrated mental health network that will: facilitate improved access for consumers across a range of services; provide private psychiatrists in the region with an opportunity to better target their skills in an innovative way; and provide multi–disciplinary support for local general practitioners in their role as primary carers. Rather than being a discrete demonstration project, all aspects of mental health service provision, related projects and services in the region have been considered in the development of this proposal.

     The evaluation team for the two New South Wales projects is headed by Dr Natasha Posner from the Social Policy Research Centre at the University of New South Wales.

- ***Queensland***

  A Queensland project, auspiced by the Toowong Private Hospital and Royal Brisbane Hospital, is not proceeding to a Live Phase.

4.7 ENHANCING RELATIONSHIPS PROJECTS

The SPGPPS has been monitoring progress with the project to progress the recommendations outlined in the report by Frank Small and Associates, *Attitudes of Health Professionals*, which was undertaken by the Mental Health Council of Australia (MHCA) with funding from the Commonwealth Department of Health and Ageing.

The current Project, titled *Enhancing Relationships Project*, involved the development of strategies, including costing for utilising and implementing the findings and recommendations of the *Attitudes of Health Professionals Project*.

In 2000, a Discussion Paper was developed by the Steering Committee overseeing the Project and a national consultation process was subsequently conducted involving stakeholders from within the mental health sector and other relevant sectors, such as general health and education.

A draft final report for the Project was subsequently developed which outlined priorities for implementation, and for future scoping. A copy of that draft was circulated for comment in July 2000 to members of the SPGPPS. The final report and its recommendations were submitted to the August 2000 meeting of the AHMAC National Mental Health Working Group. The Report was published earlier this year and copies were circulated to the SPGPPS.

At the last meeting, Mr John McGrath reported that the CDHA has not yet developed a response but has adopted some of the recommendations such as the need for funding consumer and carer participation.

Mr McGrath asked that this issue remain on the SPGPPS agenda as an Information Item.

5. OTHER BUSINESS

There was no other business.

6. CLOSE

The meeting closed at 4:00 PM.

Dr Yvonne White
Chair

Mr Phillip Taylor
Secretary