STRATEGIC PLANNING GROUP FOR

# SPGPPS

PRIVATE PSYCHIATRIC SERVICES

**TWENTY FOURTH MEETING**

**HELD AT**
**THE RYDGES PLAZA DARWIN HOTEL**
**32 MITCHELL STREET, DARWIN**
**NORTHERN TERRITORY**
**ON**
**THURSDAY, 7 JUNE 2001**

## REPORT OF MEETING

### Glossary of Acronyms and Terms used in this Report

| | |
|---|---|
| **AHIA** | Australian Health Insurance Association |
| **AHMAC** | Australian Health Ministers' Advisory Council |
| **APHA** | Australian Private Hospitals Association |
| **AMA** | Australian Medical Association |
| **AMWAC** | Australian Medical Workforce Advisory Committee |
| **CCP** | Clinical Care Pathways |
| **CDHAC** | Commonwealth Department of Health and Aged Care |
| **CDMS** | Centralised Data Management Service |
| **CFC** | Consumer Focus Collaboration |
| **CPG** | Clinical Practice Guidelines |
| **CMBS** | Commonwealth Medicare Benefit Schedule |
| **CME** | Continuing Medical Education |
| **ERP** | Enhancing Relationships Project |
| **HFPCLG** | Health Fund Psychiatric Care Liaison Group |
| **MHCA** | Mental Health Council of Australia |
| **NMHS** | National Mental Health Strategy |
| **NDI** | National Depression Initiative |
| **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 |
| **RANZCP** | The Royal Australian and New Zealand College of Psychiatrists |
| **SPGPPS** | Strategic Planning Group for Private Psychiatric Services |

The Twenty Fourth (24th) Meeting of the Strategic Planning Group for Private Psychiatric Services (SPGPPS) was held on Thursday, 7 June 2001 at the Rydges Plaza Darwin Hotel, 32 Mitchell Street, Darwin in the Northern Territory. This meeting was held back-to-back with the 8 June meeting of the Australian Health Ministers Advisory Council's (AHMAC) National Mental Health Working Group (NMHWG). A conjoint dinner between the NMHWG and the SPGPPS was held on the evening of the 7 June at the Buzz Restaurant.

## 1. OPENING

The Chair, Dr Yvonne White, opened the meeting at 10:00 am. The following representatives were in attendance.

### 1.1. PRESENT

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

| | |
|---|---|
| Dr Yvonne White | Chair SPGPPS |
| Dr Johanna Lammersma | |
| Dr Robert Broadbent | Observer |

***Australian Medical Association (AMA)***

| | |
|---|---|
| Dr Bill Pring | Chair, SPGPPS Data Collection and Analysis Project |
| Dr Choong-Siew Yong | Observer |

***Commonwealth Department of Health and Aged Care (CDHAC)***

| | |
|---|---|
| Mr Dermot Casey | Mental Health Branch and Special Programs Branch |
| Mr Peter Callanan | Private Health Industry Branch |

***Consumer Representative***
Ms Janne McMahon

***Carer Representative***
Mr John McGrath

***Private Hospitals with Psychiatric Beds (Hospitals)***
Mrs Sue Feeney
Ms Moira Munro

***Private Health Insurers (Health Funds)***
Mrs Judy Hardy
Mr Bruce Houghton (until 1400)

***Invited Guests***

| | |
|---|---|
| Ms Elizabeth Morgan | Network of Australian Consumer Advisory Groups (NOAC) |
| Professor Ian Hickie | Chief Executive Officer, beyondblue |
| Dr Petros Markou | Director, East Point Therapy Centre, NT |

***SPGPPS Secretariat***

| | |
|---|---|
| Mr Phillip Taylor | Executive Officer |
| Mr Allen Morris Yates | Principal Information Officer |

### 1.2. APOLOGIES

| | |
|---|---|
| Mr David Morton | Department of Veterans' Affairs |
| Dr Brian Kable | Royal Australian College of General Practitioners |

### 1.3 CHANGES IN REPRESENTATION

The Chair reported on the following developments concerning representation on the SPGPPS.

a. Dr Johanna Lammersma has succeeded Dr Don Grant as the RANZCP representative on the SPGPPS. Dr White acknowledged Dr Grant's contributions during his term and welcomed Dr Lammersma to the meeting.

b. Dr Robert Broadbent has resigned after thirteen years as the Executive Director of the RANZCP. Dr Broadbent reported that it is expected the new Executive Director will continue to have close involvement with the SPGPPS, when appointed. Dr Broadbent stated that he had enjoyed the experience of working with the SPGPPS and wished the

group well for the future. The SPGPPS thanked Dr Broadbent for his contribution.

c. Dr Choong-Siew Yong has succeeded Dr Eileen Burkett as the AMA Observer on the SPGPPS. Dr White welcomed Dr Yong to the meeting.

d. The Chief Executive Officer of the RACGP, Ms Liz Furler, has written to the SPGPPS and indicated that the College has decided to withdraw its representation on the SPGPPS. Ms Furler indicated that the costs related to attending as financial members of the SPGPPS, as proposed from February 2002, could not be met. The College may re-consider its position with regard to non-financial membership at a later date once the College has completed implementation of its organisational restructure. Mr Taylor reported that the Chair of the SPGPPS Forum, Dr Jonathan Phillips, would be speaking with the RACGP President, Dr Paul Hemming, on his return from overseas concerning the College's decision. The SPGPPS agreed that this matter should be held in abeyance until the outcome of discussions between Dr Phillips and Dr Hemming are known.

**RESOLVED**

1. *The SPGPPS endorses the nomination of Dr Johanna Lammersma to replace Dr Donald Grant as the RANZCP representative on the SPGPPS. The SPGPPS notes that Dr Lammermsa can be contacted at the following address:*

   *Dr Johanna Lammersma*
   *529 Port Road*
   *WEST CROYDON SA 5008*
   *Ph: 08 8340 0822*
   *Fax: 08 8346 0252*
   *Email: plammers@adam.com.au*

2. *The SPGPPS extends its appreciation to Dr Donald Grant for participating in and supporting the work of the SPGPPS as a representative of the RANZCP.*

3. *The SPGPPS extends its appreciation to Dr Robert Broadbent for supporting the work of the SPGPPS as the Executive Director of the RANZCP, and wishes him well in his future endeavours.*

4. *The SPGPPS endorses the nomination of Dr Choong-Siew Yong to replace Dr Eileen Burkett as the AMA Observer representative on the SPGPPS. The SPGPPS notes that Dr Yong can be contacted at the following address:*

   *Dr Choong-Siew Yong*
   *PO Box W84*
   *WAREEMBA NSW 2046*
   *Ph: 02 98452005*
   *Fax: 02 9845 2009*
   *Email: trickcycle@usa.net*

5. *The SPGPPS acknowledges the notice received from the RACGP, dated 6 June 2001, concerning the withdrawal of the RACGP from the SPGPPS. The SPGPPS directs that this matter be allowed to lie on the table until the outcome of discussions between Dr Jonathan Phillips and Dr Paul Hemming are known.*

## 2. REPORT OF THE 23RD MEETING OF THE SPGPPS

The SPGPPS then considered a copy of the draft report of its 23rd Meeting held on 23 February 2001 in Sydney.

**RESOLVED** (Hardy/Pring)

*That the SPGPPS approve, as a true and accurate record, the report of the 23rd Meeting of the SPGPPS held in Sydney on 23 February 2001.*

### 2.1 PROGRESS REPORT ON ACTIONS ARISING FROM THE 23RD MEETING OF THE SPGPPS

The SPGPPS noted a copy of the following progress report on the actions arising from its 23rd Meeting.

| ITEM | ACTIONS ARISING FROM THE 23RD MEETING (Refer to the Draft Report of the 23rd Meeting) | ACTION OFFICER(S) | STATUS |
|---|---|---|---|
| **1** | **Opening/Present/Apologies/Proxies** | | |
| ➢ | AMA to organise a replacement for Dr Eileen Burkett. | Dr Pring | **Done** |
| **2** | **Report on the 23rd Meeting of the SPGPPS** | | |
| ➢ | Draft and circulate report for comment. | Mr Taylor/Dr White | **Done** |
| **3.1** | **National SPGPPS Secretariat** | | |
| ➢ | Administrative Officer to be appointed 26 March. | Dr Pring/Mr Taylor | **Done** |
| ➢ | AMA to co-ordinate SPGPPS Secretariat fit out. | Mr Taylor | **Done** |
| **3.2** | **SPGPPS Operating Guidelines** | | |
| ➢ | how information discussed at meeting should be treated and reported in the record of proceedings; and appointment of a Deputy Chair. | Ms Ferry/Mr Taylor | **Done** |
| **3.3** | **SPGPPS Consumer and Carer Participation Project** | | |
| ➢ | Project Proposal to be revised. | Mr O'Hara/Mr Taylor | **Done** |
| **3.4** | **National Depression Initiative – Beyond Blue** | | |
| ➢ | Invite Professor Ian Hickie to address SPGPPS. | Mr Taylor | **Done** |
| **3.9** | **Guidelines for Determining Benefits** | | |
| ➢ | Guidelines to be circulated. | Dr Broadbent/Mr Callanan | **Done** |
| ➢ | SPGPPS Secretariat to compile a comment database. | Mr Taylor | **Done** |
| **3.11** | **SPGPPS Quality Improvement Project** | | |
| ➢ | Project Proposal to be revised | Mr Taylor/Mr O'Hara | **Pending** |
| **3.12** | **SPGPPS Data Collection and Analysis Project** | | |
| ➢ | SPGPPS Secretariat to co-ordinate Parties to sign Agreement | Mr Taylor | **Done** |
| **3.14** | **Clinical Practice Guidelines (CPG)** | | |
| ➢ | Secretariat to notify NOAC/Hospital CEOs how to obtain and comment on draft CPGs. | Mr Taylor/Dr Broadbent | **Done** |
| ➢ | Mr Callanan to provide RANZCP with the CDHAC Private Sector Industry Branch circular distribution mailing list. | Mr Callanan | **Done** |
| **3.16** | **SPGPPS Forum 2001** | | |
| ➢ | Circulate Forum Flyer. | Mr Taylor | **Done** |
| ➢ | SPGPPS Sub-committee to develop Forum Program. | Sub Committee | **Done** |
| ➢ | Secretariat to organise welcome Cocktail Party. | Mr Taylor | **Done** |
| ➢ | Secretariat to co-ordinate background paper development | Mr Taylor | **Done** |
| ➢ | Circulate Forum Materials | Mr Houghton | **Pending** |
| **3.17** | **ANZCMHN** | | |
| ➢ | Inform College of SPGPPS decision on membership. | Dr White | **Done** |
| **3.19** | **Pre-existing Ailments Rule Report** | | |
| ➢ | Respond CDHAC concerning Recommendation 16. | Dr White | **Done** |
| **4** | **New Private Sector Privacy Legislation** | | |
| ➢ | Letter to Commissioner re key issues identified by SPGPPS | Dr White | **Done** |
| ➢ | Circulate OFPC Documents Guidelines as released | Mr Taylor | **Done** |
| **7** | **Meetings 2001** | | |
| ➢ | Co-ordinate 7 June SPGPPS Meeting back-to-back with AHMAC NMHWG (8 June). | Mr Taylor | **Done** |

## 3 MATTERS ARISING

### 3.1 NATIONAL SPGPPS SECRETARIAT

The Chair reported that the Federal AMA had co-ordinated the fit out of the SPGPPS Secretariat and the CDMS at the offices of the Federal AMA in Canberra, in accordance with the following schedule.

| *Week Beginning* | Feb 19 | Feb 26 | Mar 5 | Mar 12 | Mar 19 | Mar 26 | Apr | May 1 | Jun 4 | Jul 2 |
|---|---|---|---|---|---|---|---|---|---|---|
| ***SPGPPS Secretariat & CDMS*** | | | | | | | AMA Agreement for National Model finalised and signed | | | |
| Administrative Officer Interviews | | | | | | | | | | |
| SPGPPS/CDMS office fit out | | | | | | | | | | |
| Relocate to 3rd Floor AMA House | | | | | | | | | | |
| Administrative Officer Commenced | | | | | | | | | | |
| Advertise Implementation Support Officer | | | | | | | | | | |
| Allen Morris-Yates Commences | | | | | | | | | | |
| Interview Implementation Support Officer | | | | | | | | | | |
| Implementation Support Officer Commences | | | | | | | | | | |

The SPGPPS Executive Officer, Mr Phillip Taylor, reported that Ms Bronwen van der Wal was appointed as Administrative Officer for the SPGPPS on 26 March 2001.

Mr Taylor indicated that the CDMS would also be established and staffed within the Secretariat in accordance with the above schedule. The CDMS will support the implementation of the *National Model for the Collection and Analysis of a Minimum Data Set with Outcome Measures for Private, Hospital-based, Psychiatric Services.*

Funding and implementation of the National Model and its CDMS are the subject of a separate agreement between the AMA, CDHAC, APHA and AHIA. Mr Taylor reported that this Agreement has been signed and took effect from 4 June 2001. The implementation of the National Model is being progressed under the auspice of the SPGPPS Data Collection and Analysis Project (see Agenda Item 3.12).

Mr Taylor reported that the SPGPPS website had been established at ***www.spgpps.com***. This website will be maintained by the SPGPPS Secretariat in consultation with the Federal AMA Information Technology staff. The SPGPPS asked Mr Taylor to investigate the costs associated with including a ***.au*** extension to identify it as an Australian website. It was agreed that, if there were any costs involved, then the current address would be sufficient.

### 3.2 SPGPPS OPERATING GUIDELINES

The 23rd Meeting of the SPGPPS endorsed draft SPGPPS Operating Guidelines, which had been revised by the AMA Federal Secretariat in consultation with the then AMA Legal Counsel, Ms Jane Ferry. In doing so, Ms Ferry was asked to draft appropriate clauses for inclusion in the final version of the Guidelines to deal with:

a. the selection of a Deputy Chair to assist the Chair of the SPGPPS with the responsibilities detailed under Clause 19 of the Guidelines; and

b. how information discussed at meetings should be treated and reported in the record of proceedings, particularly in relation to confidential matters.

The SPGPPS noted that, following the last meeting, Ms Ferry drafted the amendments set out below. These amendments were subsequently incorporated into the Guidelines following circulation to the SPGPPS.

- **Clause 8.2 has been amended to read:**

  *The SPGPPS will be Chaired by the Royal Australian and New Zealand College of Psychiatrists, with a Deputy Chair to be appointed under clause 8.5.*

- **A new clause 8.5 had been inserted, which reads:**

  *The Deputy Chair shall be a Representative Member, who is appointed by a majority of the Representative Members. The Deputy Chair shall hold the position until the expiration of the term of the Chair. The role of the Deputy Chair includes presiding over meetings of the SPGPPS in the absence of the Chair as described in clause 15.7; to make decisions between meetings of the SPGPPS as described in clause 15.8 and to assist the Chair in performing the duties described under clause 19 of these Guidelines.*

- **Clause 15.7 had been amended to read:**

  *The Chair, or in the absence of the Chair the Deputy Chair, shall preside at meetings of the SPGPPS. If neither the Chair or Deputy Chair is able to preside at a meeting, the Chair may nominate an alternate Representative Member to chair the meeting.*

- **Clause 15.8 had been amended to read:**

  *Decisions between meetings of the SPGPPS shall be made by the Chair, Deputy Chair and Executive Officer of the SPGPPS. They shall be entitled to exercise all or any of the powers of the SPGPPS between meetings, except in relation to Clauses 9.1, 9.4, 9.5, 9.6, 12.3, 14 and 29.1 of these Guidelines.*

- **Clause 15.9 had been amended to read:**

  *All material provided in agenda papers or handouts at a meeting of the SPGPPS, together with the detail of discussions which take place during a meeting, should be treated and kept confidential to the SPGPPS, unless otherwise determined by the meeting. Representative members and observers of the SPGPPS are able to report back to their organisations of the resolutions or basic items of discussion, in order to ensure that the Organisational Members of the SPGPPS are aware of the work currently being performed by the SPGPPS.*

The SPGPPS noted that the Guidelines will be reviewed annually.

### 3.2.1 ELECTION OF DEPUTY CHAIR

In accordance with the Operating Guidelines, the Chair indicated that this meeting needed to elect a Deputy Chair and nominations were called for from the floor. The nominees were Ms Sue Feeney and Dr Bill Pring. The SPGPPS Secretariat then conducted a secret ballot and Ms Sue Feeney was elected by a majority of votes.

**RESOLVED**

*That the SPGPPS appoints Ms Sue Feeney as Deputy Chair of the SPGPPS.*

Agenda Items 3.3 to 3.19 were then considered in accordance with the policy framework set out in the SPGPPS Strategic Plan 2000-2003.

**STRATEGIC VISION 1**

PROMOTE AND ADVANCE THE RIGHTS AND RESPONSIBILITIES OF PEOPLE WITH MENTAL HEALTH PROBLEMS OR MENTAL DISORDERS AND THEIR CARERS, AND DELIVER MENTAL HEALTH SERVICES IN THE MOST APPROPRIATE SETTING POSSIBLE, WITH AN EMPHASIS ON PRIVACY, DIGNITY AND RESPECT.

### 3.3 SPGPPS CONSUMER AND CARER PARTICIPATION PROJECT

The SPGPPS then considered progress with its Consumer and Carer Participation Project Proposal. This Project aims to have some overall long-term impact in the promotion of positive partnerships between consumers and their carers and the providers and funders of private mental health care services.

The Chair reported that a revised version of the Project proposal was re-submitted to the CDHAC Mental Health and Special Programs Branch after a previous submission had been rejected on the basis of changes that had taken place in the financial arrangements for the Branch. The second Proposal was revised in close consultation with the Branch and the SPGPPS Consumer and Carer Working Group, to account for these changes. The second Proposal also clarified the deliverables for the Project and how it would be linked to other projects that are currently being undertaken by the MHCA and NOAC.

The Chair then reported that the Branch had again declined funding the Project in its current form. A copy of the response was tabled and noted.

Ms Janne McMahon expressed disappointment that the Branch had declined funding for this Project, given that the Project proposal had undergone several careful revisions in consultation with officers from the Branch.

Mr Dermot Casey then spoke to the Branch response and explained that the current Federal Government views health service provision in Australia as a singular health care system, within which people are able to exercise choices about the care they access and receive. Mental health reform is therefore viewed as a subset of the wider heath care system.

Mr Casey indicated that the Mental Health Council of Australia (MHCA) was specifically established and funded by the Commonwealth Government to represent the mental health industry in Australia. The current Commonwealth Minister for Health and Aged Care, the Hon. Dr Michael Wooldridge MP, views the MHCA model as the main forum charged with providing advice to the Government on mental health matters. Mr Casey explained that the second Proposal implied that services provided through Medicare supported private practitioners, or through private health insurance arrangements and private hospitals, exist outside the current arrangements for advocacy of reform in Australia being progressed under the auspice of the MHCA. The Minister is satisfied that the MHCA is carrying out its charter well and that the Commonwealth would not be prepared to fund this Project, as it currently stands.

Mr Casey indicated that the Commonwealth, fully supports the aims of the Project but believes that the Commonwealth, the MHCA and the SPGPPS should meet to examine how existing and new strategies might be focussed toward achieving the shared objectives of improving consumer and carers participation across the public and the private sectors.

The AMA indicated that, while it appreciated the position of the Commonwealth, there were substantial differences between the provision of mental health care services in the public and private sectors. The value in this Project, as proposed, was that it would have resulted in a clear understanding of the current situation and what the barriers are to better integration of consumer and carer participation in both sectors. The models that can best overcome those barriers would

also have been developed and tested.

The Chair provided an historical context to the Project and it was noted that the development of the proposal was undertaken with the encouragement of Dr Wooldridge in consultation with the Branch. Mr Casey indicated, however, that the proposal does not operate within the structure that Dr Wooldridge supports, which is the MHCA.

Mr Casey explained that the SPGPPS is a strategic network of communication, which the Commonwealth has supported in its development and now funds in partnership with the other financial SPGPPS stakeholders. The Commonwealth is also willing to support and consider funding SPGPPS projects, which run in parallel with other strategies being progressed under the National Mental Health Strategy such as the *SPGPPS Data Collection and Analysis Project.* In other words, the Commonwealth is not opposed to Projects that will improve the responsiveness of services to consumers and their carers. It cannot, however, support a proposal put forward to the Minister, which does not recognize the structure that has been established and funded by the Government for that purpose.

Hospitals indicated that the MHCA and Network of Australian Consumer Advisory Groups (NOAC) have recognised the important role of the private sector in the provision of mental health services. Current mental health consumer and carer representational structures, however, remain primarily public sector in their focus. Hospitals acknowledged the attempts that are being made to correct this deficiency, however, it remains difficult to progress integrated partnerships between the public and private sector under the current representational arrangements. Hospitals were concerned to understand how involvement for all private sector stakeholders including Hospitals and Health Funds could be progressed under the current arrangements.

Consumers then outlined the current arrangements that exist for private sector consumer and carer representation through the NOAC and the MHCA. Ms McMahon confirmed that these structures are primarily public sector in their focus and that this limits the capacity for the voice of private sector consumers and carers to be acknowledged. Ms McMahon indicated that what was required were formal mechanisms in the private sector for mental health consumer and carer representation at the local (Hospital), state and national levels.

The Chair of NOAC, Ms Elizabeth Morgan, indicated that one of the strengths of the SPGPPS proposal was that it identified the levels of consumer participation. Ms Morgan spoke on the debate within NOAC as to whether there is a real difference between consumers in the private and public sectors. The SPGPPS noted that there remains a view that those who access the private sector have the financial means that enables them to access the services they need. There are, however, seriously mentally ill people in the public sector who do not have the means to access services. Ms Morgan explained that this view is changing slowly, but more work needs to be done.

In response to several questions, Mr Casey confirmed that the Commonwealth would be able to progress consumer and carer projects that are part of the current policy context and that support the broader consumer and carer approach being undertaken through the MHCA.

Health Funds indicated that a variety of consumer and carer participation models exists and that there is no one perfect model. Activity is developing very slowly in the private sector in comparison to what has occurred elsewhere. The changes that have occurred in the public sector to date have been largely driven by the requirements of the States in relation to the National Mental Health Strategy (NMHS).

Health Funds indicated that there is less of a commitment in the private sector to the NMHS for a variety of reasons and that Health Funds had an important role to play in this area as

funders. The implementation of any consumer and carer participation models in the private sector will be inextricably linked to the NMHS and the implementation of the National Standards for Mental Health Services in the private sector. Health Funds believed that we need to be working co-operatively through the SPGPPS to progress the implementation of these Standards in the private sector.

The SPGPPS noted that the current negotiations between NOAC and the MHCA, to progress partnerships within the MHCA for consumer and carer representation, did not specifically address the gaps highlighted in the second SPGPPS Proposal. Current mechanisms are primarily focussed on enhancing the relationships between existing structures. To expand this further to address the gaps that exist, particularly at the state level, is extra work. Mr Casey indicated that the States needed to think more broadly about their responsibilities toward consumers and carers. Mr Casey re-iterated that consumer and carer participation is the core business of the MHCA.

Hospitals pointed out that work is underway in the private sector and that Ms McMahon had already undertaken visits in South Australia (The Adelaide Clinic, Fullarton Private Hospital and Kahlyn Private Hospital), Western Australia (The Perth Clinic) and Victoria (The Albert Road Clinic). While these private hospitals acknowledged the importance of consumer and carer representation they did not believe that such representation could be progressed within their current structural arrangements. The SPGPPS Project, however, was viewed as an important first step toward addressing the current situation.

Mr Casey indicated that he was looking for an integrated holistic approach whereby private sector facilities are linked to what is happening in the public sector.

Mr John McGrath, as Chair of the MHCA, indicated that the networks that currently exist have acknowledged the role of the private sector. Mr McGrath indicated that a lot of hard work needs to be done to enable the voice of private sector consumers and carers to be heard. The SPGPPS noted that while the MHCA is currently under pressure in terms of it's funding, it would be prepared to negotiate with the SPGPPS and the Commonwealth concerning a joint project. Mr McGrath explained that this would enable the private sector issues to be appropriately blended with the work being undertaken by the MHCA in relation to the public sector. The MHCA would need to look at the implications, logistics and funding for such a conjoint project. Mr McGrath felt that the MHCA Board would be able to make this work a priority.

The Chair indicated that the SPGPPS would also need appropriate funding if it were to be part of such a conjoint project. The current funding arrangements for the SPGPPS do not include funding for Projects.

Hospitals were concerned to ensure that the SPGPPS is the focus for such a project as Hospitals see the SPGPPS as their peak body.

Ms Morgan indicated that NOAC was of the view that the progress that has been made over the past few years in the private sector was quite astounding and largely due to the work of the SPGPPS as articulated in the *SPGPPS Strategic Plan 2000-2003*. Ms Morgan felt strongly that a Project in this area should be a conjoint project between the SPGPPS and the MHCA.

It was agreed that a meeting of the SPGPPS Consumer and Carer Participation Working Group should be convened with appropriate representatives from the MHCA and the Commonwealth to progress this matter and explore the available options. These deliberations should also be informed by any recommendations arising from the SPGPPS 2001 National Forum.

**RESOLVED**

*That the SPGPPS requests the Secretariat to co-ordinate a meeting between the SPGPPS Consumer and Carer Participation Working Group and the representatives from the MHCA and the CDHAC Mental Health and Special Programs Branch, to consider how to best progress consumer and carer participation in the private sector. The Chair of the SPGPPS is to convene this meeting via teleconference.*

**STRATEGIC VISION 2**

REDUCE THE MORBIDITY AND MORTALITY ASSOCIATED WITH MENTAL ILLNESS IN AUSTRALIAN SOCIETY.

## 3.4 NATIONAL DEPRESSION INITIATIVE AND NATIONAL ACTION PLAN FOR DEPRESSION - *BEYOND BLUE LIMITED*

The Chair reported that on 23 October 2000, the Minster for Health and Aged Care, Dr Michael Wooldridge MP announced that the National Depression Initiative had become a legal company called *beyondblue Limited*. Professor Ian Hickie was subsequently appointed as the Chief Executive Officer of beyondblue, which is located at 50 Burwood Road in Hawthorne, Victoria. Professor Hickie was invited and agreed to address this meeting of the SPGPPS on the objectives and activities of beyondblue. The Chair welcomed Professor Hickie to the meeting.

***Background***

In opening his address Professor Hickie provided a background to the beyondblue initiative and drew on the survey of *Mental Health of Australians* to emphasise the prevalence of depression in the Australian community (see below).

| Twelve-month prevalence of mental disorders in Australian adults | Males | | Females | |
|---|---|---|---|---|
| | % | Population estimate | % | Population estimate |
| Any depressive disorder | 4.2 | 275,300 | 7.4 | 503,300 |
| Any anxiety disorder | 7.1 | 470,400 | 12.0 | 829,600 |
| Any substance use disorder | 11.1 | 734,300 | 4.5 | 307,500 |
| Any mental disorder | 17.4 | 1,151,600 | 18.0 | 1,231,500 |

*Source: Andrews G, Hall W, Teesson M, Henderson S. The mental health of Australians. Mental Health Branch, Commonwealth Department of Health and Aged Care, 1999.*

Professor Hickie identified that the key data arising from that survey indicated that:

- 62% of current cases do not get any mental health intervention;
- 75% of those who do receive care are dealt with in the primary care setting;
- 15% only of those with a common disorder receive any evidence-based intervention; and
- 800,000 Australians/year suffer depression.

The key issues arising that national depression initiatives need to respond to include:

- Ongoing lack of community awareness and ongoing stigma;
- Lack of a broad public health approach and specific preventative programs;
- Unmet need for treatments;
- Substantial social, cultural and health access inequities;

- Lack of chronic and/or continuous care;
- Lack of integrated medical and psychological care;
- Poor access to non-pharmacological treatments; and
- Lack of culturally and geographically relevant models.

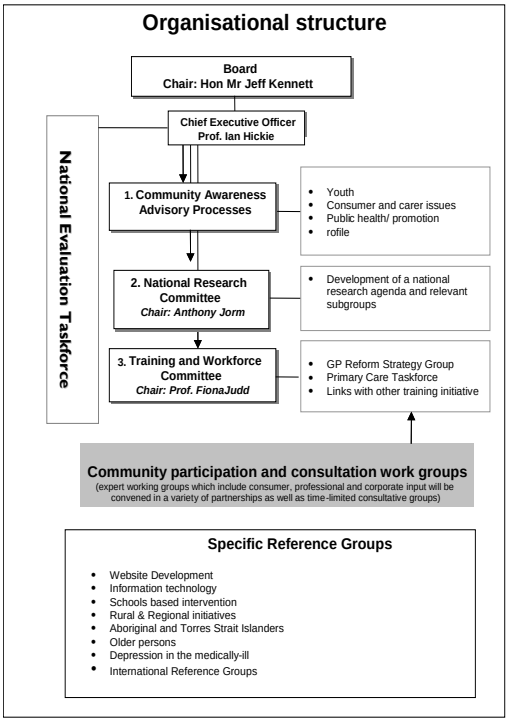
Professor Hickie indicated that a major reference for the beyondblue was the Commonwealth Government's *National Action Plan for Depression* which acknowledges the:

- Population Health focus of National Mental Health Strategy – Second Plan;
- National Survey of Mental Health and Wellbeing (1997); and
- 'New' Public Health Approach, which emphasises the spectrum from health promotion through disease prevention to, improved quality of management.

***beyondblue - A national depression initiative***

Professor Hickie explained that the Commonwealth and Victorian Governments had provided $35m over five years for the beyondblue initiative. Other States and Territories that are yet to come on board are SA, ACT, WA, QLD, and TAS. Corporate sponsorship (not pharmaceutical companies). The SPGPPS noted that beyondblue is a not for profit private company with a board comprised as follows.

1. Honourable Jeff Kennett, Chairman
2. Ms Jenny Pickworth, Lawyer, WA Health
3. Professor Harvey Whiteford, University of QLD
4. Hon. Ms Caroline Hogg, Former Member of Victorian Parliament
5. Ms Gwen Wilcox, Executive Director, Australian Institute of Management
6. Mr John McGrath, Chairman, Mental Health Council of Australia
7. Mr Garry McDonald, Patron NSW Branch of Anxiety Disorders Foundation of Australia
8. Dr Paul Hemming, President Royal Australian College of General Practitioner



In terms of levels of intervention, Professor Hickie explained that beyondblue would focus on the social and organisational factors that may impart risk or promote resilience and/or result in earlier presentations for effective care, including schools, workplaces and community organisations. Community leadership and participation are important and it is intended that the community-based organisations that will take up a role will include:

- Non-mental health and community-based (sport, religious, arts, cultural, schools etc);
- Corporations (workplace opportunities) in both private and public domain;
- Medical communities (hospitals); and
- Medical and/or mental health associations (e.g. cancer councils; dementia-related).

Professor Hickie then identified the following five priority areas for action as:

1. Destigmatising depression by increasing community awareness;
2. Promoting prevention and early intervention of depression;
3. Promoting consumer and carer issues;
4. Promoting primary care training
5. Strategic Research

***1. Destigmatising depression by increasing community awareness***

beyondblue is promoting community awareness through a range of activities, which include a national media seminar, media commentary, public forums (with a particular focus on rural and remote) and community profiles (using elite athletes).

Strategic partnerships and linkages have been established with Reach Out (an internet-based youth information service), Rotary Australia and with several other forums.

Community awareness initiatives are directed towards the identification of basic symptoms and signs of depression, the promotion of health seeking behaviours, understanding of pathways to care and community responses.

The SPGPPS noted that media/marketing campaigns for beyondblue have included:

- Faces of Depression
- National Literacy campaign
- NOT 'One size fits all'!

Professor Hickie reported that the beyondblue Internet site, ***www.beyondblue.org.***au, was launched in April 2001. The website focuses on information provision, consumer involvement, promotion of relevant mental health links.

***1. Promoting prevention and early intervention of depression***

beyondblue is promoting prevention and early intervention through:

- Schools-based program 2002-2005
- Compass Project for severe disorders in youth (2001-2002)
- Workplace-based recognition
- Novel IT-based service delivery
- Depression in medically-ill
- Peri-natal program
- Older age program

***2. Promoting Consumers and Carer issues***

This is being achieved through focus groups for key concerns which will address stigma in the workplace, insurance (travel, life, medical), discontinuities in care, lack of non-pharmacological care, networks of support, National Coalition for common affective

disorders

***3. Promoting Primary Care Training***

beyondblue is establishing partnerships with General Practice through the RACGP and the Australian Divisions of General Practice. These partnerships are directed toward improving training and structural reform. Beyondblue is also looking at opportunities for public education, social and attitude change for non-medical primary care and alternative forms of primary care.

Professor Hickie indicated that primary care is the major service focus of the initiative, given its largely untapped capacity to treat large numbers of currently untreated people with a mental health problem or disorder. Primary care also has a major role to play in psychoeducation and destigmatisation through medicalisation. The Commonwealth has allocated a $120m package to enhance primary care assessment with specific mental health Commonwealth Medicare Benefits Schedule (CMBS) Items for GPs. Enhanced GP care requires additional training, ongoing clinical supervision and Continuing Medical Education.

***4. Strategic Research***

beyondblue is approaching the issues of strategic research through the development of key summaries to guide policy, particularly in relation to primary care based interventions and depression prevention programs. Secondary analyses of existing data and preventative programs with research component will be supported.

Professor Hickie then drew attention to the following international experiences that are relevant to beyondblue.

- Defeat Depression (UK – mid 1990s)
- DART (USA)
- Sustained public health campaigns
- Multiple levels of community and professional engagement
- Community understanding

***Conclusion***

In summary Professor Hickie indicated that the task for beyondblue is not easy. This initiative, however, does provide an opportunity for a major public health focus on common mental disorders and will engage the public in support for ongoing research, training and service enhancement. beyondblue will also enable appropriate political pressure to be bought to bear for service reform as well as facilitate a wider understanding of aetiological and treatment issues.

In closing, Professor Hickie indicated that the challenge of all public health initiatives is to increase or decrease the health divides and respond appropriately to the diverse needs of the Australian community.

There followed a question and answer session and the Chair thanked Professor Hickie for his presentation.

### 3.5 PROMOTION PREVENTION AND EARLY INTERVENTION FOR MENTAL HEALTH

The CDHAC Mental Health and Special Programs Branch reported on progress with the *National Plan for Promotion, Prevention and Early Intervention for Mental Health* (Action Plan 2000) and the monograph titled, *National Plan for Promotion, Prevention and Early Intervention for Mental Health* (Monograph 2000). These documents were developed under a joint Commonwealth, State and Territory Government initiative aimed at improving mental health outcomes for the Australian population. As such they are part of the broad national

population health approach in Australia.

Mr Casey explained that these documents are intended to provide a policy and conceptual framework for promotion and prevention and early intervention for mental health in accordance with the key themes of the Second National Mental Health Strategy.

Copies of the documents were circulated directly to members of the SPGPPS in January 2001 under cover of correspondence, which provided details on how to provide feedback together with information on national forums. Mr Casey indicated that these documents will be updated over time, but not before 2002 because of the enormous resources required. Professor Graham Martin is responsible for the national consultations and members of the SPGPPS were invited to provide feedback by contacting Professor Martin directly on 08 8357 5788, or via the Internet website at: www.ausinet.flinders.edu.au.

***Strategic Vision 3***

Reduce the stigma associated with mental health problems and mental disorders.

### 3.6 ENHANCING RELATIONSHIPS PROJECT

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 is being undertaken by the MHCA with funding from the CDHAC. 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. Representatives of the SPGPPS participated in the consultation process.

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 August 2000 meeting of the AHMAC National Mental Health Working Group (NMHWG). The Report was published earlier this year and copies circulated to the SPGPPS.

The CDHAC Mental Health and Special Programs Branch reported that a National Mental Health Education and Training Advisory Group had been established in 2000 to progress mental health workforce, education and training issues. The Advisory Group has been developing a draft set of *National Practice Standards for the Mental Health Workforce*. Mr Casey explained that these Standards are intended to progress issues of skills, attitudes and knowledge of mental health professionals. The Standards are being developed in consultation with the five mental health disciplines. The SPGPPS noted that the draft Standards would be considered by the 8 June 2001 meeting of the NMHWG. The Advisory Group will be seeking the endorsement of NMHWG to progress to the next stage of development of a broader consultation plan.

There was consensus that there would need to be very wide consultation on such Standards, particularly given the substantial industrial implications for employers, professional groups, unions and funder organisations. Mr Casey indicated that there were important implications for quality issues, particularly in relation to the National Standards for Mental Health Services and the National Quality and Safety Standards Council.

**STRATEGIC VISION 4**

FACILITATE ACCESS TO THE RANGE OF SETTINGS AND SERVICES THAT EXIST WITHIN THE PRIVATE SECTOR, ACROSS THE WIDER HEALTH CARE SYSTEM, AND IN RURAL AND REMOTE AREAS, WHILE ENSURING CONTINUITY OF CARE.

### 3.7 EARLY DISCHARGE AND HOSPITAL IN THE HOME

The CDHAC Private Sector Industry Branch reported on developments with the National Evaluation of Private Sector Based Early Discharge and Hospital-in-the-Home Trials, which were conducted in two stages. Stage One of the evaluation involved three trials.

1. The St Frances Xavier Cabrini Domiciliary Palliative Care Program
2. The South Australian Psychiatric Patient Trial
3. The Victorian Rehabilitation Patient Trial

Further Hospital-in-the-Home/Early Discharge Trials were subsequently approved and evaluated as part of Stage Two of the National Evaluation. These included:

- Hospital-to-Home Trial (Adelaide Community Healthcare Alliance)
- Victorian Private Psychiatric Early Discharge Trial
- Epworth Hospital-in-the-Home Pilot Project (Victoria)

#### 3.7.1 Report of the National Evaluation

The Report from Stage One of the National Evaluation was released in October 2000 and copies were circulated to the SPGPPS. The SPGPPS has considered and commended the Report, but expressed caution as to the generalizability of the results.

The Final National Evaluation Report (Stage Two) has been approved for publication and should be released shortly. Copies will be forwarded to the SPGPPS as soon as they are available.

#### 3.7.2 Health Legislation Amendment Act (No. 1) 2001

Mr Callanan reported that the *Health Legislation Amendment Bill (No.3) 2000* was introduced into the House of Representatives on 31 May 2000. The Bill amended (in part) the *National Health Act 1953* to enable the private health industry to fund outreach services, that is, alternative models of health care delivery, as a direct substitute to in-hospital care for admitted patients who are acutely ill. The House of Representatives passed the Bill, with minor amendment, on 7 February 2001. The Bill was granted Royal Assent on 21 March 2001 and the Bill is now known as, the *Health Legislation Amendment Act (No. 1) 2001*. A copy of the Act is available from the Australian Parliament House Web-site at http://www.aph.gov.au.

#### 3.7.3 Guidelines for Outreach Services

Mr Callanan reported that, under the Act, Hospitals and Health Funds seeking to provide outreach services to private patients would be required to gain Ministerial approval before providing outreach services. Only approved services will be covered by hospital table insurance arrangements. To gain approval, hospitals will be required to meet the Guidelines. The Guidelines will be used to determine whether an outreach service should be specified under the new section 5D of the *National Health Act 1953*.

Mr Callanan explained that draft Guidelines have been developed with reference to a comprehensive evidence base that included existing public sector hospital-in-the-home guidelines and public and private sector evaluation reports. It is expected that the final guidelines will be available shortly.

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The final outreach Guidelines will assist the Minister for Health and Aged Care (or their nominated Delegate) to select (and approve) those outreach services that meet the Guidelines. Approval will be granted for a specified period and approved outreach services will need to reapply to the Minister if they wish to continue the service beyond the specified period, before existing approval expires. It will be a requirement that those programs previously approved report on the results of a review of the outreach service prior to additional approval being granted.

Mr Callanan indicated that additional approval from the Minister, or their Delegate, will be necessary if a new or substantially different service is developed with a view to this being offered as part of the outreach program. Submission for approval will need to be made prior to the new or different service being implemented.

The Commonwealth recognizes that the majority of hospitals, including those currently offering outreach services, already have in place protocols and policies that would be similar to these draft Guidelines and, it is anticipated, the final Guidelines.

Mr Callanan indicated that in addition to satisfying the Guidelines, any facility seeking approval as an outreach service provider must:

i. have a State or Territory license or registration certificate, and

ii. be declared by the Commonwealth Minister for Health and Aged Care to be either:
   - a private hospital under subsection 23EA(1) of the *National Insurance Act 1973*;

   or
   - a day hospital facility under subsection 5B(1)of the *National Health Act 1953*

The SPGPPS noted that the outreach service is a voluntary program. It is not mandatory for Health Funds and Hospitals to participate. The agreed parties need to be specified in the outreach program proposal. Mr Callanan indicated that, under the Act, the Minister has the power to revoke an outreach service's approval and this may occur if the Minister believes that the minimum Guidelines are not being satisfied.

### 3.7.4 Status of People Receiving the Outreach Service

Mr Callanan reported that people admitted to the Approved Outreach Services, regardless of how they enter the program, are **admitted patients of the hospital** until discharge from the program. Such people may be admitted to an Approved Outreach Service following an episode of in-hospital care, that is, their admitted patient status simply continues for the duration of their care.

Alternatively, patients may be admitted to an outreach program (and hospital simultaneously) without having to have been physically admitted to the hospital itself. For example a person may be assessed as suitable in their place of residence, at the GPs rooms, or in the Accident and Emergency Department of the approved hospital. The patient must satisfy the admission/eligibility criteria for the program and belong to a participating Health Fund if they wish to claim benefits from their Hospital table.

Mr Callanan reported that the next step will be to look at the Hospital and Ancillary Tables of Benefits and how they relate to interventions that occur at the primary care level.

## 3.8 REVIEW OF 2ND TIER BENEFITS

The CDHAC Private Sector Industry Branch reported that as part of the CDHAC review of the default table of benefits, representatives from private hospitals and the health insurance

industry met on 21 February 2001 with the Branch to discuss the proposed new arrangements for 2nd Tier Benefits.

Some of the difficulties with these Benefits included:

- lack of transparency of the level of benefits payable;
- difficulties with classification of the different groups of hospitals by State;
- problems related to the resolution and disputation process; and
- payment benefits for contracted hospitals for episodes of any particular treatment.

Mr Callanan reported that, to address these difficulties, the Commonwealth has put forward a proposal in which the Commonwealth will determine the 2nd Tier Benefit level for episodes of hospital treatment, rather than health funds calculating this Benefit level, as is required under the current arrangements. This approach is intended to provide more certainty concerning the benefit level paid under current 2nd Tier arrangements and to enable hospitals to provide informed financial consent to consumers in such circumstances.

The Commonwealth proposal includes a *2nd Tier Advisory Committee*, which will have a role in considering applications from hospitals for 2nd Tier payments. This means that instead of facilities having to apply to every Health Fund from which they wish to obtain 2nd Tier Benefit payments, they would apply to this Committee. The Committee would have a role in assessing each application and making a recommendation to all funds indicating whether the facility had met the criteria or not.

The new arrangements would continue to require hospitals and day hospital facilities to demonstrate that they meet specified criteria such as those relating to quality of care. The criteria, however, have greater transparency and objectivity. These changes provide private hospitals and day hospital facilities with more certainty about eligibility for 2nd Tier Benefits and the amount of those benefits.

The proposed new arrangements are set out in the Branch circular titled, *HBF 690 PH 430*, which is located on the Internet at:

http://www.health.gov.au/pubs/circfinl/circulars/circulars00-01/690_430.pdf

Mr Callanan indicated that the Department has obtained comments from the private health industry (including representatives from private hospitals, day hospitals and health funds) regarding a draft proposal for new 2nd Tier provisions. The Department is currently finalising revised arrangements in response to such comments and in consultation with the industry is working towards implementing the new 2nd Tier Benefit arrangements by the end of this financial year.

Mr Callanan indicated that one of the issues for the criteria for these provisions proposes that Hospitals with psychiatric patients will collect recommended outcome measures in accordance with the protocols specified in the *SPGPPS National Model for the Collection and Analysis of a Minimum Data Set with Outcome Measures for Private Psychiatric Services*.

The SPGPPS considered this proposal and there was consensus that the original intention was for participation in the implementation National Model to be a voluntary process. Hospitals indicated that they would raise this matter with the APHA Psychiatric Sub Committee at its meeting scheduled for 8 June 2001 and advise the SPGPPS Secretariat and Mr Callanan of the outcome of the deliberations on this matter.

**RESOLVED**

*The SPGPPS requests that the APHA Psychiatric Sub-Committee to consider and advise on the proposal that the new provisions for 2nd Tier Benefits include*

*criteria that requires Hospitals to collect recommended outcome measures in accordance with the protocols specified in the SPGPPS National Model for the Collection and Analysis of a Minimum Data Set with Outcome Measures for Private Psychiatric Services.*

### 3.9 GAP INSURANCE LEGISLATION

The CDHAC Private Sector Industry Branch reported that *Health Legislation Amendment (Gap Cover Schemes) Bill 2000*, passed through the House of Representatives on 12 April 2000 and was introduced to the Senate on 13 April. The Senate referred the Bill to a Senate Committee of Inquiry, which reported on 9 May. The Senate moved a number of amendments, including:

- that there be provision for an independent review of the operation of schemes after July 2002;
- that informed financial consent be provided in writing and that patients must acknowledge receipt of this advice; and
- that doctors must disclose any financial interest that they may have in recommending particular products or services to a patient insured under a scheme.

Mr Callanan reported that the Legislation was passed by both Chambers of Parliament and received Royal Assent on 27 June 2000 and was proclaimed on 11 August 2000. A copy of the Bill was circulated to members of the SPGPPS last year.

The AMA indicated that an article on informed financial consent has appeared in the AMA journal *Australian Medicine*. The article was accompanied by a form to assist doctors in providing an estimate for patients of the likely costs of their in-hospital or Day Surgery Unit elective procedures.

Mr Callanan reported that in the December 2000 quarter, 65% of in-hospital services provided to private patients were delivered without a gap. The Government is planning an advertising/information campaign to inform consumers of changes to the way gaps may be dealt with. Doctor representative groups (including the RANZCP and AMA) are being briefed by the CDHAC on the campaign. Kits explaining how gap cover schemes work are being distributed to doctors and a video forum, to allow doctors Australia-wide to pose questions about the schemes, will be held on 5 June. The CDHAC contact for any further information is Lil Bryant in Public Affairs on phone (02) 6289 5216.

There followed a discussion on some of the misleading aspects of the advertising/information campaign. The AMA and the RANZCP indicated that the consultation process had been less than satisfactory and it was noted that consumer groups, in particular, had not been involved.

### 3.10 GUIDELINES FOR DETERMINING BENEFITS FOR PSYCHIATRIC INPATIENTS

The Chair reported on progress with the *Guidelines for Determining Benefits for Health Insurance Purposes for Private Patient Hospital-Based Psychiatric Care*, which were endorsed by the SPGPPS earlier this year.

Mr Callanan reported that the Guidelines were subsequently issued by the Department via the industry Circular HBF 694 PH 433.

The Chair reported that the last meeting of the SPGPPS agreed that the Guidelines should be reviewed in a timely and efficient manner and the CDHAC Private Health Industry Branch agreed to initiate the review process later in 2001. The review process will reflect stakeholder experience with the Guidelines and changes in the legislation relating to community-based care (refer Agenda Item 3.7).

Mr Taylor reported that the SPGPPS Secretariat has started to compile a database of comments and concerns that arise with the implementation of the Guidelines. The comments and concerns raised by stakeholders to date are as follows.

- There is continuing concern over the two funding levels, which exist in New South Wales.
- Under point *6. Treatment Options* in the Guidelines there may be a need to take account of any confidentiality issues that may arise in the use and documentation of the care plans.
- Remuneration for the time taken in supervising care plans may also need to be taken into account.
- While it is important for the Guidelines to be ground in evidence-based treatments, in practice this often does not apply due to the complexity of some psychiatric problems and the nature of some forms of psychotherapeutic treatment.
- Consumer and carers are concerned to ensure that the issue of relapse intervention is dealt with more explicitly under the section *2. Service Provision* of the Guidelines. This is particularly important to consumers and carers in minimising the incidence of relapse and maximising recovery.

Ms Feeney provided an explanation of the background to the development of the two funding levels, which exist in New South Wales.

### 3.11 SPGPPS QUALITY IMPROVEMENT PROJECT

The SPGPPS then considered progress with its Quality Improvement Project Proposal. This Project was intended to:

- broadly define what constitutes quality and efficiency for private sector mental health services and determine the most appropriate quality improvement tools and techniques for use in the private sector setting;
- build on the National Model for the Collection and Analysis of a Minimum Data Set for Private, Hospital-based, Psychiatric Services;
- review the National Mental Health Standards and their appropriateness for adoption in private sector psychiatric services;
- facilitate the development of education and training initiatives in the implementation of outcome measurement and continuous quality improvement for health professionals working in the private sector; and
- determine what sort of information needs to be provided for consumers and carers on the quality of the mental health services available in the private sector.

The Chair reported that the proposal for this Project was submitted to the CDHAC Mental Health and Special Programs Branch for consideration toward the end of last year. The Branch subsequently responded and indicated that the Project proposal would need to be reviewed to account for the changes that had taken place in the financial arrangements of the Branch. This review has not yet taken place given the priority placed on the revision of the Consumer and Carer Project Proposal by the last meeting of the SPGPPS.

It was also noted that the Chair of the SPGPPS Working Group that developed the proposal, Ms Sue Feeney, had been recently appointed as the SPGPPS representative on the Commonwealth's National Standards Implementation Working Group (NSIWG).

Ms Feeney reported that the purpose of the NSIWG is to progress the implementation of the National Standards for Mental Health Services. Membership of the NSIWG comprises the

Commonwealth, State and Territory jurisdictions, consumer and carer representatives and accrediting agencies. Ms Feeney indicated that her role on the NSIWG is to provide representation for private sector psychiatric services, as well as providing the Government and private sector with an opportunity to discuss matters of mutual concern. Ms Feeney also reported on the meetings between the Australian Council on Healthcare Standards (ACHS) and the APHA Psychiatric Sub Committee concerning the current status of accreditation using the ACHS EQuIP and the linkages with the National Standards for Mental Health Services. Ms Feeney indicated there was a strong commitment from private sector toward quality and quality improvement programs.

Mrs Hardy indicated that the Health Fund Psychiatric Care Liaison Group (HFPCLG) has discussed this issue and the attempts that private hospitals are making to link their existing standards to the National Standards. There are, obviously, some Standards that do not apply and the HFPCLG has agreed to work with Hospitals toward full implementation of the Standards. Mrs Hardy believed that events had largely overtaken the proposed SPGPPS project.

Mr Peter Callanan and Mr Bruce Houghton reported on related activities underway in the private sector and the Chair requested that information on these activities be forwarded to the SPGPPS Secretariat for circulation.

It was agreed that the SPGPPS should retain its Quality Improvement Working Group as an active sub-committee of the SPGPPS. It was further agreed that the SPGPPS representative on the NSIWG was well placed to represent the interest of the private sector in relation to the implementation and use of the National Standards. It was also agreed that there should be a survey of Hospitals concerning their experience with the National Standards.

**RESOLVED**

1. *The SPGPPS recommends that any problems stakeholders are experiencing with the National Standards for Mental Health Services should be reported through the Chair of the SPGPPS Quality Improvement Working Group, Ms Sue Feeney.*
2. *The SPGPPS requests that Ms Sue Feeney bring any issues that arise with the use of the National Standards for Mental Health Services in the private sector to the attention of the Commonwealth's National Standards Implementation Working Group, in her capacity as SPGPPS representative.*
3. *The SPGPPS requests that its Hospital Representatives, in consultation with the SPGPPS Secretariat, develop a structured survey of Hospitals concerning their current utilisation of the National Standards for Mental Health Services.*
4. *Mr Callanan and Mr Houghton are asked to forward information on other quality activities in the private sector that are relevant to the SPGPPS stakeholders.*

### 3.12 SPGPPS DATA COLLECTION AND ANALYSIS PROJECT

The SPGPPS then considered progress with its Data Collection and Analysis Project, which 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.*

The Chair reported that the CDHAC, Health Funds, and Private Hospitals subsequently agreed to contribute to the funding necessary to implement the National Model, and to establish a *Centralised Data Management Service* (CDMS) within the National SPGPPS Secretariat, at the offices of the Federal AMA in Canberra.

An *AMA Agreement for Services* was prepared to facilitate this process and secure the services of Mr Allen Morris-Yates to manage the implementation of the National Model and the CDMS. The AMA, CDHAC, APHA and AHIA are Parties to this agreement.

Mr Taylor reported that all parties signed the Agreement in April. Mr Allen Morris-Yates was subsequently appointed as the SPGPPS Principle Information Officer responsible for the implementation of the National Model and commenced duties on 4 June 2001.

Mr Morris-Yates reported that the National Model would be implemented in accordance with the following schedule.

| *MONTH* | 1 JUN 2001 | 2 JUL 2001 | 3 AUG 2001 | 4 SEP 2001 | 5 OCT 2001 | 6 NOV 2001 | 7 DEC 2001 | 8 JAN 2002 | 9 FEB 2002 | 10 MAR 2002 | 11 APR 2002 | 12 MAY 2002 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ***Development of Materials & Processes*** | | | | | | | | | | | | |
| Training and reference materials for service providers | ■ | | | | | | | | | | | |
| Outcome Measures Database for Hospitals | | ■ | ■ | ■ | | | | | | | | |
| Data repository and data matching and validation tools | | ▒ | ▒ | ▒ | ■ | ■ | ■ | | | | | |
| Semi-automated data analysis and reporting tools | | | | | | | | ■ | ■ | | | |
| Data analysis, reporting and distribution procedures | | | | | | | | | | ■ | | |
| Documentation of tools and procedures | | ▒ | ▒ | ▒ | ▒ | ▒ | ▒ | ▒ | ▒ | ▒ | ■ | |
| ***Milestones*** | | | | | | | | | | | | |
| All training and reference materials distributed | | ✓ | | | | | | | | | | |
| Hospitals' able to submit data to Funds and the CDMS | | | | | ✓ | | | | | | | |
| CDMS able to accept data from Hospitals and Funds | | | | | | | | ✓ | | | | |

Mr Morris-Yates reported that an advertisement appeared in *The Australian* newspaper on Saturday, May 5 2001 for an Implementation Officer to assist with the implementation of the National Model and the CDMS. The SPGPPS noted that only one applicant had applied and was subsequently interviewed. Mr Morris-Yates indicated that, while the applicant was highly qualified and the obvious choice for the position, there was a $25,000 shortfall between the salary budgeted for and what the applicant was prepared to accept.

Mr Casey indicated that the CDHAC Mental Health and Special Programs Branch would be prepared to undertake a variation to the current Agreement to meet the applicant's salary requirement. It was agreed that the applicant should be informed of this development and asked to confirm whether they wished to proceed with taking up the offer.

**RESOLVED**

*The SPGPPS requests that the SPGPPS Secretariat ascertain whether the current applicant for position of SPGPPS Implementation Officer wishes to proceed with taking up the position. If so, the SPGPPS acknowledges the commitment of the CDHAC Mental Health and Special Programs Branch to*

*undertake a variation to the current AMA Agreement for Services to meet the applicant's salary requirements.*

### 3.13 CLINICAL CARE PATHWAYS (CCPS)

The Chair reported that the SPGPPS has been monitoring the RANZCP scoping exercise to explore the potential use of Clinical Care Pathways (CCPs) in psychiatry and mental health services.

The RANZCP reported that this scoping exercise was completed in 1999 and a project report was provided to the CDHAC. 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 (ECT), 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.

The CDHAC reported that it has agreed to publish the report on the scoping exercise as a discussion paper for consideration and comment with particular reference to the recommendations from the report.

The CDHAC is keen for the RANZCP to explore the potential contribution CCPs can make to mental health care and to use feedback on the discussion paper to assist in determining the best way to progress future work and processes after the consultation stage is completed. The RANZCP is currently looking at the costs and logistics involved with the consultation phase and whether there will be Commonwealth funding available for this process.

A discussion followed and the RANZCP and CDHAC clarified several aspects of the intended consultation process. The SPGPPS was of the view that the discussion paper should be widely circulated for comment.

### 3.14 CLINICAL PRACTICE GUIDELINES (CPGS)

The Chair reported that the CDHAC has provided funding for the RANZCP to develop CPGs. The RANZCP reported that the development and implementation of CPGs Project comprises four stages covering development, dissemination and implementation, evaluation and review, and update. The Project involves the development of evidence-based GPGs for clinicians and for consumers in the following priority areas.

1. Schizophrenia
2. Anorexia nervosa
3. Deliberate Self Harm Behaviour
4. Major Depression
5. Bipolar disorder
6. Panic disorder and agoraphobia

The CPGs are being developed in accordance with the principles detailed in the National Health and Medical Research Council's, A Guide to the Development, Implementation and Evaluation of Clinical Practice Guidelines (1998 and 2000).

It was noted that following the last meeting of the SPGPPS:

- the SPGPPS Secretariat notified NOAC and the CEOs of all Hospitals how to obtain copies of the draft CPGs.
- Mr Callanan provided the RANZCP with a copy of the CDHAC Private Sector Industry Branch circular distribution mailing list.

- the SPGPPS submitted comments on the draft CPGs for Panic Disorder/Agoraphobia and Major Depression.

The RANZCP reported that draft CPGs for Anorexia Nervosa were released recently, with the deadline for feedback set at 31st August 2001. The SPGPPS noted that the deadline for feedback on the draft CPGs for Panic Disorder/Agoraphobia and Major Depression had also been extended to the 30th June 2001. It was noted that all available CPGs could be obtained from the College website: www.ranzcp.org. Hard Copies can be obtained by contacting:

Ms Christine Burke,
RANZCP CPG Project Officer
Department of Psychological Medicine
Nepean Hospital
PO Box 63
Penrith NSW 2751
Ph: +61 2 47 342435
Fax: +61 2 47 34 3343
Email: burkec@wahs.nsw.gov.au

A discussion followed and SPGPPS representatives provided further comments on the draft documents, which were noted by the RANZCP.

The RANZCP indicated that draft CPGs for Schizophrenia will soon be available and posted on the website. Draft CPGs are currently being prepared for Deliberate Self Harm and Bipolar Disorder. It is expected that these drafts will be available for consultation later this year or early next year.

**STRATEGIC VISION 6**

Deliver mental health services in the most efficient and cost effective manner possible without compromising quality.

### 3.15 INTEGRATED NATIONAL MENTAL HEALTH SERVICE PROJECTS.

The Chair reported that the State and Territory Health Departments in partnership with the private sector, is establishing a number of Integrated National Health Service Projects. The Projects may be seen as the equivalent of Coordinated Care Trials within the mental health sector. However, a crucial difference is that the focus of the Integrated Projects is at the provider level, rather than the consumer level. Each Project is funded using a mix of funds from the relevant State/Territory, Commonwealth Medical Benefit Schedule funds, and funds made available through the Australian Health Care Agreements.

#### 3.15.1 Aim and Purpose

The CDHAC Mental Health and Special Program Branch reported that the aim of the 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.

Mr Casey indicated that 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.

### 3.15.2 Project development and implementation

Mr Casey then explained that the development and implementation of each project involves three phases.

***Phase 1 - Planning***

This phase uses Commonwealth funds, and has taken 12 to 24 months for each of the Projects to complete. The initial purpose of this phase is for the local area participants to determine the feasibility of conducting the Project. This is determined by thorough consultation and negotiation with a full range of stakeholders in each local area. If the decision to proceed is affirmative, a detailed Project proposal is developed by the Project participants/stakeholders in the local area and presented to CDHAC for approval to proceed to the Live Phase.

***Phase Two Live Phase.***

This phase will take approximately 20-24 months using a mixture of Commonwealth and State/Territory funds.

***Phase Three Wind-Down***

The length of this phase will vary depending on local needs and will use a mixture of Commonwealth and State/Territory funds. The plan for the Wind-Down Phase is included in the project proposal developed during the Planning Phase.

### 3.15.3 Current Status

The SPGPPS noted that four projects, one in Victoria, two in New South Wales, and one Queensland, are in different phases of development and implementation as set out below.

***VIC*** 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 with support and advice provided by the University of Wollongong's Centre for Health Service Development.

***NSW*** Two projects are at an advanced planning stage in NSW and it is anticipated that both projects will commence the Live Phase on 1 July 2001.

- 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.
- 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.

***QLD*** A Queensland project involving the Toowong Private Hospital and Royal Brisbane Hospital will soon commence its planning phase.

### 3.15.4 Evaluation

Mr Casey reported that all projects would be evaluated.

- The evaluation of the Public and Private Partnerships Project in Victoria is being conducted by the University of Melbourne's Centre for Health Program Evaluation.

- The two New South Wales will use the same evaluator and the selection process for this is nearing completion.

The Chair reported that the Reference Group for these Projects met on Friday, 23 March 2001 and a brief discussion of these Projects followed. Dr White spoke on the concerns of private psychiatrists, particularly in relation to the lack of a project looking at private psychiatrists being supported by the public system and public community teams. This is a concern for private psychiatrists given the difficulties they experience in accessing public sector services for their patients. Mr Casey noted this concern and reported that the project in Illawara will fund all the mental health services for the area regardless of how those services are provided.

**Strategic Vision 7**

Develop secure information management systems for private sector mental health services to support appropriate quality improvement mechanisms.

### 3.16 SPGPPS NATIONAL FORUM 2001

The Chair reported on progress with the SPGPPS National Forum on access to psychiatric services to be held at the Rydges Capital Hill Hotel in Canberra on Friday, 3 August 2001. A Welcome Cocktail Party will be held on the evening of Thursday, 2 August 2001 at the Kurrajong Hotel, 8 National Circuit, Barton. The Cocktail Party will be held between 6:30 pm and 8:00 pm. Forum Delegates are also welcome to visit and meet the staff of the newly established National SPGPPS Secretariat, prior to the Cocktail Party, between the hours of 5:00 pm and 6:30 pm on 2 August. The Secretariat is located on the 3rd floor of AMA House, which is conveniently located behind the Kurrajong Hotel at 42 Macquarie Street Barton.

The Chair indicated that the Forum will be used to build on the work undertaken by the SPGPPS to date and enhance collaborative relationships between providers, funders, consumers and carers. Ultimately, the Forum seeks to clearly articulate a shared vision of the fundamental principles necessary to support better access to psychiatric services for private sector stakeholders.

#### 3.16.1 Forum Flyer and Delegate Registrations

The Secretariat reported that the Forum flyer was distributed following the last meeting of the SPGPPS. To date approximately 60 Delegates had registered to attend the Forum, which includes representatives from the AMA, the learned medical Colleges, Divisions of General Practice, nursing and allied health professions, private hospitals, private health insurance funds, the Commonwealth and consumers and carers.

#### 3.16.2 Draft Program, Speakers and Background Papers

The Chair reported that a draft program for the Forum had been developed and all invited Speakers had confirmed their availability. The SPGPPS noted a copy of the draft Program, which had been circulated with the agenda and papers for the meeting.

#### 3.16.3 Background Papers Development Schedule

The Chair then explained that to assist Delegates in preparing for the Forum, Speakers were currently preparing background papers on access issues relating to their topic area in collaboration with designated members of the SPGPPS. Background papers will be included in the materials for Delegates attending the Forum. The SPGPPS noted that the schedule for Background Papers preparation was as follows.

**KNA:** *Overview of the Private Sector* (Mr Houghton/Mr Callanan)

**SGS1**: *Continuum of Care Models in the Private Sector* (Prof. Philip Morris/Mr Callanan/Dr White)

**SGS2:** *Mental Health Workforce* (Prof. Ross Kalucy/Dr Phillips/Mr Taylor)

**SGS3:** *Rural Mental Health* (Dr Monash/Dr Kable)

**SGS4:** *Intensive Psychiatric Treatments* (Dr Eng Kong Tan/Dr Honnery/ Dr Pring)

**SGS5:** *Consumers and Carers* (Ms McMahon/Ms Feeney/Mr McGrath)

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

| | | |
|---|---|---|
| 1 May - 21 May | 3 weeks to prepare preliminary draft Background Papers. | **Done** |
| 21 May | First Draft of Background Papers to SPGPPS Secretariat. | **Done** |
| 28 May | National Forum Working Group Teleconference. | **Done** |
| 29 May - 28 June | 4 weeks to revise Background Papers. | ☐**Pending** |
| 29 June | Final Background Papers to SPGPPS Secretariat. | ☐**Pending** |
| 18 July | Conference materials dispatched | ☐**Pending** |

Mrs Hardy reported that there had been some discussion at the recent NOAC meeting about the desirability of private hospitals funding the participation of consumers and carers to enable them to attend the Forum. Hospital representatives agreed to raise this issue with the APHA Psychiatric Sub-Committee meeting scheduled for 8 June 2001. There was consensus that it was important to ensure that consumers and carers are able to participate in the Forum.

Hospitals were concerned to ensure that the content of Forum papers addressed issues that are relevant to Hospitals and their staff, particularly in relation to the current crisis in mental health nursing. Hospitals acknowledged that the SPGPPS Secretariat had responded and communicated these concerns to all those involved in the preparation of Background Papers.

The Secretariat also reported that Dr Jonathan Phillips had secured a commitment from *Eli Lilly* to fund a post Forum publication that would incorporate articles developed from the background papers, speakers presentations and the Small Group Sessions. The SPGPPS endorsed the preparation of such a publication and thanked Dr Phillips and Eli Lilly for supporting this effort.

**RESOLVED**

*The SPGPPS requests that the SPGPPS Secretariat, following the SPGPPS National Forum 2001, undertake preparation of a post-Forum publication. The SPGPPS wishes to extend its gratitude to Eli Lilly for supporting the production costs involved with this publication.*

### 3.17 ACCESS TO PSYCHIATRIC SERVICES

The SPGPPS then considered progress with the meetings that are being held to progress the possibilities for improving access and enhancing services provided by private psychiatrists, including possibilities for desirable changes in the CMBS for long-term intensive psychiatric treatment.

The Chair reported that on Monday, 23 April 2001, the NMHWG and the RANZCP convened an exploratory workshop for key informants to analyse and discuss issues pertaining to national mental health workforce concerns and to reach consensus on how the next stages would be progressed.

The meeting was held in Melbourne at the offices of RANZCP. The meeting was co-chaired by the then President of the RANZCP, Dr Jonathan Phillips, and a nominee of the NMHWG, Dr Margaret Tobin. The focus of the workshop was on industry responses to AMWAC

Report, *The Specialist Psychiatry Workforce in Australia*, including solutions which would involve:

- new approaches to education and training;
- collaboration between primary care and the specialist mental health workforce; and
- incentives to improve access to specialist mental health services.

The SPGPPS then noted a copy of the draft Report of this Workshop, which had been circulated with the agenda and papers.

The RANZCP reported that the outcome of the Workshop was agreement that a small group was needed to take the issues detailed in the draft Report forward. This group should also be able to address the concerns of various stakeholders in a more coordinated and effective manner. The SPGPPS noted that some of the suggestions given with regards to the proposal included that the group:

- consist of 6-8 members, plus a secretary and a project officer;
- meet for 1-2 hours monthly via teleconference, and 1-2 times a year on a face-to-face basis;
- nominees need not necessarily represent their organizations, but rather must have an interest, commitment and ability to move things forward;
- must be appropriately funded (approximately $50,000) and have appropriate executive support; and
- should be modeled after that of SPGPPS with the intention of merging this group with SPGPPS after two years of operation.

The RANZCP indicated that a copy of the final Report and the recommendations arising from the Workshop had been included on the agenda for the 8 June 2001 meeting of the NMHWG. Dr Broadbent indicated that funding was a key issue to progress this work as it involves the entire mental health workforce, not just psychiatrists.

The SPGPPS acknowledged that, if the NMHWG supported this proposal, then the Commonwealth would have to address the funding issue. Mr McGrath, as Chair of the MHCA, indicated that, while the Council saw psychiatrists as the key group that needed to undertake leadership in this area, the task was much wider than the psychiatrist workforce.

Consumers were concerned to ensure that in this process the treating role of psychiatrists is not lost in favour of a consultation liaison role with GPs. Any shift in roles must result in better access to both psychiatrists and GPs.

### 3.18 PRE-EXISTING AILMENTS RULE

The Chair reported that the last meeting of the SPGPPS considered a copy of the Executive Summary and Recommendations from the report into the operation of the current pre-existing ailment rules that apply to private health insurance members. In considering the Recommendations the last meeting of the SPGPPS paid particular attention to Recommendation 16, which asks the SPGPPS to:

> *…develop a guide to assist health funds determine whether or not a psychiatric illness was pre-existing by identifying which psychiatric illnesses are typically clustered or contingent on one another, and which conditions can be generally regarded as distinct and unrelated.*

The last meeting was of the view that SPGPPS did not have sufficient expertise to undertake this work. Identifying which psychiatric illnesses are typically clustered or contingent on one another, and which conditions can be generally regarded as distinct and unrelated, is a complex area that is currently the subject of a major international research effort. At the last meeting there was consensus that an alternative and manageable approach might be to develop a timely and socially just determination mechanism and associated right of appeal processes.

The Chair reported that following the last meeting, the SPGPPS had responded to the CDHAC and explained why the SPGPPS found it difficult to progress Recommendation 16 in its current form. Mr Callanan indicated that the decisions involved with the Pre-existing Ailment Rule were medical decisions and that it was important that the appropriate specialists (in this case psychiatrists) are involved in the further development of this area.

The RANZCP suggested that, while it is difficult to progress Recommendation 16 in its current form, it may be possible to develop a guide for Health Funds as to an appropriate mechanism and appeal process that could be used when trying to determine whether a psychiatric illness is pre-existing or not. It was agreed that the SPGPPS would write again to the CDHAC suggesting this approach. It was agreed that, if the CDHAC were supportive of this approach, then the SPGPPS would establish a small working group comprised of SPGPPS representatives from RANZCP, AMA, Health Funds, Hospitals and Consumers to undertake this work. Several SPGPPS representatives indicated that they would be prepared to participate on such a working group.

**RESOLVED**

*The SPGPPS requests that the Chair write to the Acting Secretary of the CDHAC Private Health Industry Branch, Ms Perry Sperling, and indicate that the SPGPPS is prepared to undertake the steps necessary to develop a guide for Health Funds as to an appropriate mechanism and appeal process to be used when determining whether a psychiatric illness is pre-existing or not. The letter should indicate that, if the CDHAC were supportive of this approach, then the SPGPPS would establish a small working group to undertake this work. The following SPGPPS representatives have agreed to participate on the working group.*

| | |
|---|---|
| *Dr Jo Lammersma* | *RANZCP* |
| *Dr Bill Pring* | *AMA* |
| *Mrs Judy Hardy* | *Health Funds* |
| *Ms Moira Munro* | *Hospitals* |
| *Ms Janne McMahon* | *Consumers* |

### 3.19 NEW PRIVATE SECTOR PRIVACY LEGISLATION

The Chair reported that, earlier this year, the Federal Privacy Commissioner wrote to the SPGPPS concerning the approach to implementing the new private sector privacy legislation. The Privacy Amendment (Private Sector) Act 2000 (Cth) (the Act) was passed by Parliament on 6 December 2000 and received Royal Assent on 21 December. For many organisations, including health services, the new private sector provisions will commence on 21 December 2001.

The SPGPPS noted that because the National Privacy Principles embodied in the legislation are high level principles, the Office of the Federal Privacy Commissioner (OFPC) is providing detailed guidance and assistance both before and after the new legislation comes into effect. The OFPC is attempting to work closely with stakeholders to develop guidelines under the Act that help to clarify the application of the legislation.

The Chair indicated that the last meeting of the SPGPPS expressed some concern over a lack of clarity of the extent and nature of the OFPC consultation process, particularly in relation to the inclusion of mental health consumers and carers. The SPGPPS was of the view that there should be multiple opportunities to provide comments and feedback to the OFPC. Following the last meeting, the SPGPPS wrote to the OFPC and highlighted key issues that are relevant to the new legislation and the people who receive treatment for a mental health problem or disorder in the private sector.

The SPGPPS noted that, since its last meeting, the OFPC had released three major draft guideline documents on the new legislation for public consultation in the lead up to 21 December 2001 as follows:

| **Draft OFPC Document Title** | **Release Date** | **Submission Deadlines** |
|---|---|---|
| *1. Draft Code Development Guidelines* | 9 April 2001 | Friday, 15 June 2001 |
| *2. Draft National Privacy Principles Guidelines* | 7 May 2001 | Friday, 6 July 2001 |
| *3. Draft Health Privacy Guidelines* | 14 May 2001 | Friday, 20 July 2001 |

The Secretariat reported that as these documents have been released, they have been forwarded to the members of the SPGPPS via email. SPGPPS Secretariat has also provided hard copies, on request. The SPGPPS noted that all the documents are also available at http://www.privacy.gov.au/rfc/index.html, in a variety of formats.

The Secretariat reported that at this point in time, these documents represent the Federal Privacy Commissioner's thinking and the intention of the consultation process is to get feedback from as many people as possible on the ways in which these documents might be improved. The Commissioner has stressed the importance of achieving the right balance in these documents and welcomes input from the SPGPPS.

There followed a discussion on the size and complexity of the documents released to date. Of these documents it was thought that the Draft Health Privacy Guidelines carried a range of implications for psychiatrists, Health Funds, GPs, Hospitals and consumers and carers.

The Chair urged Members and Observers to read this document carefully and respond on behalf of their respective constituency and to also forward any comments they wish to have included in the SPGPPS response to the Secretariat. Mr Allen Morris-Yates was asked to consider the document carefully and advise on any implications for the implementation of the National Model. The SPGPPS also agreed to invite the Privacy Commissioner to address the next meeting of the SPGPPS.

**RESOLVED**

1. *The SPGPPS requests that Members and Observers carefully consider the Draft Health Privacy Guidelines, prepared by the Office of the Federal Privacy Commissioner, and forward any comments they wish to have included in an SPGPPS response to the SPGPPS Secretariat. The SPGPPS submission should propose a moratorium on penalties for at least the first year of operation of the new private sector privacy legislation.*
2. *The SPGPPS requests that Mr Allen Morris-Yates consider the Draft Health Privacy Guidelines and advise on any implications for 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.*

3. *The SPGPPS requests the Federal Privacy Commissioner, Mr Malcolm Crompton, be invited to attend and address the 28 September 2001 meeting of the SPGPPS on the Health Privacy Guidelines.*

## 4. FEDERAL BUDGET AND MENTAL HEALTH

The CDHAC Mental Health and Special Programs Branch provided an overview of the mental health strategies detailed in the Federal Governments Budget for 2001-2002. It was noted that a major focus would be improving community understanding and attitudes about mental health, mental illness and suicide, and improving the availability of national mental health tele-counselling, information and referral services.

Mr Casey explained that activities targeting health and related professionals, the media, and the general community would seek to improve mental health literacy, encourage help seeking behaviours and address stigma and discrimination.

The Commonwealth will continue to work with the public and private sectors to secure the quality and improve the efficiency and effectiveness of mental health services. Key strategies include developing a module to review mental health services against the National Mental Health Standards and developing routine consumer outcome measurements for implementation in public sector mental health services. Mr Casey mentioned that some of the projected outcomes would include the following.

- Implementation of the MindMatters program, including provision of access by all secondary schools to the resource kit and professional development activities by June 2002.
- Revision of the *Achieving the Balance* media resource kit by June 2002.
- Implement the second phase of *Aussinet* including the engagement of key stakeholders and the development of an agreed work-plan.
- Final evaluation of the Australian Trans-cultural Mental Health Network to be completed by December 2001.
- Development of a useable pilot version of the national database for mental health information, referral and tele-counselling including the engagement of pilot partners by December 2001.
- All specialised public mental health services to collect adult consumer outcome measures and casemix measures by June 2003.
- All specialised public mental health services to have begun the process of quality improvement (as set out in the *National Standards for Mental Health Services*) through a suitable review process by June 2003.
- Community-based mental health care strengthened by an increase in expenditure on mental health services delivered in the community as a proportion of mental health expenditure.

The SPGPPS noted that the budget for mental health strategies was $107.4 million in 2000 – 2001 and $87 million in 2001 – 2002.

### 4.1 The Initiative – Mental Health: More Options, Better Services

Mr Casey explained that, under this initiative, the Commonwealth will provided $120.4 million over four years to improve the quality of care provided through general practice to Australians with a mental illness.

This package will address the significant barriers to the early identification and treatment of mental health disorders in Australia. It provides more appropriate remuneration for focused diagnosis and care of patients presenting to GPs with mental health problems. The initiative aims to:

- encourage better identification and informed clinical care for mental health patients through financial support to GPs;
- provide new CMBS items to allow GPs trained in psychological medicine to provide mental health counselling to patients;
- provide GPs with quality education and training to support the above, and access to additional allied mental health support; and
- provide a new CMBS item for psychiatrists to provide consultancy assistance to GPs through a case conference item involving GP, Psychiatrists and one other professional. In emergency situations the provision will allow for consultation between the GP and a psychiatrist.

The SPGPPS noted that the budget allocation for this initiative over the next 4 years would be $4.2 million in 2001-02, $24.6 million in 2002-03, $39.9 million in 2003-04 and $51.7 million in 2004-05.

## 5 MEETINGS 2001

The SPGPPS noted the schedule of remaining meeting dates for 2001 as follows.

| Meeting | Date | Time | Venue | Location |
|---|---|---|---|---|
| SPGPPS National Forum 2001 *Welcome Cocktail Party* | Thursday, 2 August | 6:30 pm - 8:00 pm | Kurrajong Hotel<br>8 National Circuit<br>Barton ACT | Canberra |
| SPGPPS National Forum 2001 | Friday, 3 August | 9:00 am – 4:00 pm | Rydges Capital Hill<br>Cnr National Circuit & Canberra Avenue<br>FORREST ACT 2603<br>Ph: 02 6232 0319<br>Fax: 02 6295 3377<br>Rate: $156 per night | Canberra |
| 25th Meeting SPGPPS | Friday, 28 September | 10 am – 4:00 pm | RANZCP Headquarters<br>309 La Trobe Street<br>Melborne VIC 3000 | Melbourne |
| 26th MeetingSPGPPS back-to-back with AHMAC/NMHWG | Thursday, 6 December | 10 am – 4:00 pm | TBA | Adelaide |

There being no further business the meeting closed at 4:00 pm.

Dr Yvonne White
Chair

Mr Phillip Taylor
Secretary