SPGPPS
Private Mental Health Alliance

Australian Medical Association

The Royal Australian and New Zealand College of Psychiatrists

The Royal Australian College of General Practitioners

Mental Health Consumers and Carers

Australian Private Hospitals Association

Australian Health Insurance Association

Australian Government Department of Health and Ageing

Australian Government Department of Veterans' Affairs

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SPGPPS News

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SPGPPS News provides a brief summary of some of the issues being progressed by our Private Mental Health Alliance. As such it is intended to stimulate discussion and debate concerning the delivery of mental health services in the private sector. SPGPPS News does not, therefore, necessarily represent the views of participating organisations, unless otherwise stated. Further information can be obtained from the SPGPPS Website at www.spgpps.com.au, or by contacting the Secretariat on 02 6270 5438.

Editor's Desk

Dr Bill Pring

This Edition of SPGPPS News focuses on our SPGPPS working groups, which largely oversee the work of the SPGPPS. In addition, we have an update on SPGPPS involvement with the various government inquiries into mental health and Dr Andrew Page elaborates on how our sector can work collaboratively on making the best use of outcomes data.

Government Inquiries into Mental Health.

SPGPPS representatives recently appeared before the Parliamentary Inquiry into Health Funding. The public hearing focused on the private health sector with particular regard to one of the Committee's terms of reference:

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

Innovative Models Working Group (IMWG)

From February to August this year, IMWG, held a series of meetings to draft an Interim Draft Discussion Paper titled *The Assessment of Models of Funding Service Delivery for Private Psychiatric Services*. As the title suggests, the paper is not so much a blueprint for the sector as a stimulus to discussion about funding reform and the best way to provide the care that consumers and their carers want. The Chair of the IMWG, Mr Phillip Taylor, gives a brief overview of the Paper in this edition.

Information Strategy Working Group (ISWG)

Does the mental health sector need to measure consumer satisfaction with the care they receive? The National Mental Health Information Priorities Workshop, held in February 2004, thought it was a priority.

In late 2004, ISWG began to examine the feasibility of using the US devised NRI/MHSIP Consumer In-patient Survey instrument as a consumer perception of care (CPoC) measure in the private sector.

With input from the National Network of Private Psychiatric Sector Consumers and Carers (National Network), the CPoC Project has reached a stage of coming to an agreement between the Australian Medical Association, the Australian Government Department of Health and Ageing, and Queensland Health to pilot the measure. For more detail, read the article in this Edition.

SPGPPS Substance Abuse and Dependency Working Group (SDWG)

Drug and alcohol abuse is a major issue for the mental health sector. At the same time, good data on best practice in dealing with the problem is sparse. To help remediate this situation, the SPGPPS invited Professor John Saunders from the Centre for Drug and Alcohol Studies, Department of Psychiatry, School of Medicine, University of Queensland, to address the 40th SPGPPS Meeting.

The SPGPPS has considered the issues raised by Professor Saunders and reconvened its SDWG to undertake the following, under the Chairmanship of Mr Maurie O'Connor from the Department of Veterans' Affairs,

- Promote the best practice scenarios outlined in the Professor Saunders presentation.
- Develop a *Position Paper on the Diagnosis and Treatment of Substance Abuse and Dependency for Private Mental Health services.*
- Develop a subsection for the *Guidelines for Determining Benefits for Health Insurance Purposes for Private Patient Hospital-based Mental Health Care* on best practice in the diagnosis and treatment of people with substance abuse and dependency.
- Disseminate the information from Professor Saunders presentation, with consideration of the reality that many practitioners have little exposure to information about drug and alcohol treatment.

An overview of Professor Saunder's impressive presentation is given in this Edition.

National Network

Our National Network held it's second face-to-face meeting for the year on 15/16 August 2005 at RANZCP Headquarters. Our thanks go to RANZCP for their generous support of the Network in hosting these meetings twice a year, gratis.

The National Network hosted a booth at the recent TheMHS conference in Adelaide to promote a wider recognition of the Network, its aims and activities. Reception was very positive.

Attendees commented that the Network was fulfilling a real need for advocacy on issues peculiar to the private mental health sector, as well as those affecting all mental health consumers and their carers.

Dr Bill Pring is the Editor of SPGPPS News, the official AMA observer on the SPGPPS, and Chair of the ISWG.

Substance Use Disorders and the Private Hospital Role

Professor John Saunders

Professor John Saunders from the Centre for Drug and Alcohol Studies, Department of Psychiatry, School of Medicine, University of Queensland, and the Alcohol and Drug Service, Royal Brisbane and Women's Hospital gave a presentation to the 40th SPGPPS Meeting on *Substance Use Disorders and the Private Hospital Role.*

Overview of the problem – a shifting landscape

Substance Use in the Australian General Population: Findings from the recent National Drug Strategy Household Surveys

	Use in Past Year				*% Change 1998 - 2001*
Substance	*1993*	*1995*	*1998*	*2001*	
Alcohol	73.0	78.3	80.7	82.4	+2%
Tobacco	-	-	22.7	19.5	-14%
Cannabis	12.7	13.2	17.9	12.9	-28%
Heroin	0.2	0.4	0.8	0.2	-75%
Amphetamines	2.0	2.1	3.7	3.4	-8%
Cocaine	0.5	1.0	1.4	1.3	-7%
Any illicit drug	14.0	17.0	22.0	16.9	-23%
Injected illicit drugs	0.5	0.6	0.8	0.6	-25%

As the table shows, use of drugs is not static. Over the 1990's there was an epidemic of heroin related problems including overdose and dependency. What is seen now are the mental health complications associated with amphetamine usage.

Over the last century there has been an array of diverse opinion about what constitutes substance abuse disorder. It is now recognised that there is a spectrum of substance use and misuse of all psycho-active substances. For most substances most of the population will be absent. A number, using some substances like alcohol, will be in the low risk category. A smaller number will use certain substances in ways that are known to have negative consequences. A smaller number still are those with a definable clinical syndrome of dependency, which acts in many ways like a disease process.

The Dependence Syndrome

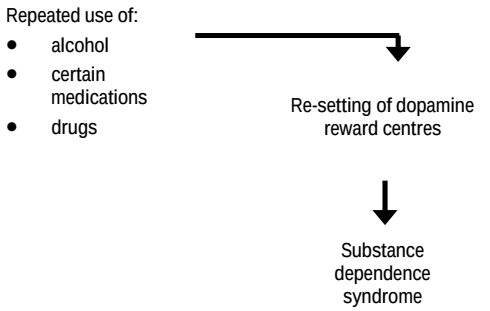
Dependence syndrome is essentially a condition that occurs as the result of an initial period of repeated substance use. It is associated with neurochemical changes, which sets up a syndrome with a *life of its own*. It is a psychobiological syndrome, which comprises an inner *drive* to take alcohol or drugs regardless of harmful consequences, preoccupation with substance use, and sometimes withdrawal symptoms. The criteria are set out below.

Three of the following elements occurring repeatedly for one year are necessary for the diagnosis according to International Classification of Diseases (ICD-10).

- Impaired control over substance use.
- A strong desire to take the particular substance.
- Preoccupation with substance use (given greater priority than other activities).
- Increased tolerance.
- Withdrawal symptoms on cessation of substance use, or relief of withdrawal symptoms by further use.
- Continuation of use despite harmful effects.

Developments in Neuro-scientific Knowledge

Over the last fifteen to twenty years there has been a major investment in neuro-scientific research into substance abuse. Arising from this research it is now known that substance dependence syndromes have profound biological underpinnings. What happens is a resetting of the dopamine reward pathways in the midbrain as depicted in the following diagram.



The biological mechanisms of substance dependence identified are nuclei in the mid-brain concerned with reward and reinforcement, including the: ventral tegmental nucleus and nucleus accumbens.

The changes in neurotransmission are multiple, deep-seated and lingering. Some of these changes last for as long as the lifespan of the individual. The Syndromes can be chronic and quickly re-activated upon further exposure to the substance, which does not represent a relapse due to choice, but as a consequence of biological drives. Genetic factors account for around 50% of the reason why some people develop substance abuse disorder.

Treatments for Alcohol Dependence Syndrome

There is a major disjunction between what is shown by the research to be best practice and what is done 'in practice' as shown by the table below.

Treatments for Alcohol Misuse		
Best practice	Poor Evidence	Available
Brief interventions		Just say no!
CBT		CBT (limited)
MET		MET (limited)
12-step approaches		12-step approaches
Acamprosate		Acamprosate (limited, if at all)
Naltrexone		Naltrexone (limited)
	Analytic psychotherapy	Analytic psychotherapy
	Confrontation therapy	Confrontation therapy
	Supportive counselling	Supportive counselling
	Benzodiazepines (post-detox)	Benzodiazepines (post-detox)
	Anti-depressants	Anti-depressants
	Aversion therapy	
	Hypnosis	
	Residential treatment	

It is very difficult to arrange for cognitive-behaviour therapy (CBT) or motivational enhancement therapy (MET), unless the patient is privately insured and the health insurance carried covers for psychologist fees. There is massive under-access of pharmacological approaches, whereas a range of bad practices is readily available in the current treatment system. Some of these are relatively old approaches.

Use of Pharmacotherapies for Alcohol Dependence

Though pharmacotherapies for alcohol dependence represent a very important component of best practice, the rate of pharmacological intervention by GPs is around 3%. By contrast, currently, at the Alcohol and Drug Service at the Royal Brisbane and Women's Hospital, 80-90% of inpatients with alcohol dependence are discharged on acamprosate or naltrexone, and 80% of outpatients at Biala Alcohol and Drug Service, at The Prince Charles Hospital are treated with acamprosate or naltrexone.

Treatments for Other Substance Misuse: What is Known?

Cannabis Dependence

Hospitals are seeing a raft of mental health complications associated with cannabis use. CBT is promising but there is limited evidence. Cannabinoid antagonists are currently being trialled.

Heroin Dependence

Substitution treatment - There is solid evidence for the effectiveness of methadone and buprenorphine in reducing harm and deaths.

Antagonist pharmacological treatments - There is some evidence for the effectiveness of naltrexone for highly motivated clients with good social support.

Rehabilitation and supportive approaches - There are good individual outcomes, but the attrition rate is high and the approach is unpopular with many.

Psycho-stimulant Dependence

Modest benefits can be gained from cognitive-behaviour therapy (4 sessions plus). There is a clear benefit from twelve-step facilitation, but it is culture dependent.

There is no established pharmacotherapy for psychostimulant amphetamine dependence, but there are some trials attesting to the moderate effectiveness of disulfiram and medafinil. Dexamphetamine substitution is also a useful modality with this population.

Serotonin reuptake inhibitors relieve depression in the first 4-6 weeks, but have no long-term benefit

The Reach of Treatment

There is massive under-availability of treatment and the treatment that is offered is often inappropriate. Out patient treatments are well supported by the evidence base. However, the average number of therapy sessions attended in ambulatory services is 2.2. This amounts to roughly an assessment session followed by one follow-up session.

A private hospital program is a delivery mechanism, not a treatment modality where, in engaging the person in treatment, in a structured program in an in-patient setting, the provision of evidence-based therapy is achieved in a way that is difficult to achieve in ambulatory settings.

Professor John Saunders may be contacted at*: *leonie_mohr@health.qld.gov.au

Assessing Models of Funding Service Delivery for Private Psychiatric Services

Mr Phillip Taylor

In 2003, the SPGPPS established an Innovative Models Working Group (IMWG) to encourage the uptake of innovative models mental health care and funding in the private sector. To achieve that goal, the IMWG developed a set of *General Principles and Recommendations*, which supported the substitution of overnight admitted patient care with less restrictive models of care. In progressing these it became clear that markedly different views were held in the private sector concerning the practicality, efficacy and feasibility of such models. In response, the SPGPPS significantly broadened the IMWG Terms of Reference in 2004 to increase the focus on the merits, or otherwise, of different models of care and funding and the barriers to their uptake in the private sector.

The IMWG subsequently invited providers, funders, and consumers and their carers, to put their case on alternative models of mental health care and funding to the SPGPPS Between February and August 2005, the IMWG met on several occasions to analyse these different perspectives. From these discussions, the IMWG agreed to prepare a discussion paper, for the SPGPPS that identifies and discusses funding arrangements that can:

- reduce incentives for inpatient care;
- increase incentives for alternative models to inpatient care;
- provide training in best practice alternatives; and
- meet the desired needs of consumers and their carers.

Interim Discussion Paper

The IMWG's Interim Discussion Paper titled, ***The Assessment of Funding Service Delivery for Private Psychiatric Services***, firstly identifies what are the agreed fundamental expectations of consumers, and their carers. It then goes on to discuss some of the options available for the funding of comprehensive models of service delivery that would enable the needs of consumers and carers to be most effectively met. Certain of the options could be implemented or at least trialled in the short term whilst the remainder will most likely require further consideration and debate. Any legislative or regulatory constraints, and how they might be addressed, are also discussed.

Expectations of Consumers and Carers

Consumers know what does, and what does not, work for them. Therefore, models of service delivery and their associated funding mechanisms must be judged on their capacity to meet the fundamental expectations of consumers and their carers. They need services that:

- facilitate continuous and coordinated high quality care that is delivered by a range of services across a variety of settings;
- provide access to a range of specialist treatment and support services;
- respond to the needs of consumers and their carers in a timely and efficient manner that promotes recovery and support gains made;
- provide a choice of treatment programs;
- provide the most facilitative environment for appropriate treatment and care;
- prevent co-payments and out-of-pocket expenses; and
- protect patient privacy and confidentiality.

Psychiatrist's Perspective

Psychiatrists believe that the private mental health system is a complex system, which is balanced in a particular way at present, which has led to high effectiveness and high cost-efficiency. Any changes to the homeostasis of the system at present may lead to cost inefficiencies and poor outcomes, and so psychiatrists are advocating for evolutionary change, not revolutionary change. In the Discussion Paper, psychiatrists present the following innovations.

Option 1: Improve Remuneration for Consultations with Carers

Review the two item numbers, which are available under the Medicare Benefits Schedule (MBS), for services to carers of patients being treated under that schedule for mental illnesses. Those items are used occasionally, but not used a great deal.

Option 2: New Item Numbers for Allied Health Professionals Under Medicare Funding

Make MBS item numbers available under limited circumstances, for consultations provided by allied health professionals under the supervision of psychiatrists. Such professionals might include clinical psychologists, psychiatric nurses, social workers and occupational therapists.

Option 3: Health Insurance Fund Financed Allied Health Initiative

Include referral to psychologists as part of medical and hospital products in the private health insurance arrangements.

Option 4: Psycho-social Rehabilitation Projects

Initiate psychosocial rehabilitation projects in the private sector that not only cater for the private hospital insured group, but also allow for some involvement of non-insured patients. This initiative would be slightly more complicated, but could have significant benefits.

Option 5 - Increase Private Psychiatrist Rebates

MBS rebates for private psychiatrists have declined in real terms over the last 20 years. There has been a conscious policy of limiting the increase of rebates for specialists other than GP specialists, which includes private psychiatrists.

Alternative Models For Funding Hospital-Based Psychiatric Care

The Interim Discussion Paper acknowledges that the current per–diem based funding models provide strong financial disincentives for hospitals to change from the delivery of services principally within the overnight inpatient service setting, to alternative settings, including sameday and outreach. The Paper identifies five alternative models of funding of hospital-based psychiatric services

Programme–based Per–diem Payment Model

With some variation across Health Funds and Hospitals, the most common payment model at present is one in which benefits for both overnight inpatient and ambulatory care are stratified by program and paid on a per–diem basis with step down points set on the basis of length of stay estimates per program.

Casemix–based Per–diem Payment Model

Under this model patients are classified under an agreed casemix classification system, for example, the Australian Refined Diagnosis Related Groups (AR-DRGs). A specific per diem payment schedule is agreed for each casemix group. Based on analyses of historical data, Health Funds and hospitals would, in the course of their normal commercial in confidence negotiations, agree the positioning of step down points as well as the quantum of benefits payable for each day.

Casemix–based Episodic Payment Model

Under this model patients are classified under an agreed casemix classifications system (e.g. AR–DRG's). A specific per episode payment schedule is agreed for each casemix group. Based on analyses of historical data, health funds and hospitals would, in the course of normal commercial in confidence negotiations, agree the quantum of benefits payable for each episode. The principal feature of this model, and that which distinguishes it from per–diem based funding models is that hospitals share more equally in the financial risk associated with variations in patients' needs for care.

Prospective Case Payment Model

Under this model, hospitals are paid a fixed sum for the provision of care to the patient for an identified period, most probably the twelve months following their initial admission to the hospital. The amount of the payment would depend on the initial assignment of the patient to one or other case classification. The prospective payment would be expected to cover all aspects of the patient's care as determined by the hospital in consultation with the patient's treating psychiatrist. Within that context of joint responsibility with the treating psychiatrist for the patient's care, the hospital is free to allocate that funding as required.

Bundled Prospective Payment Model

In this model, Health Funds and Hospitals would negotiate a bundled payment, which would then be used by the hospital to provide care to *all* of the Health Fund's members who might require care in the period covered by the payment. The quantum of the payment would be based on an analysis of the historical service needs of the Health Fund's members at that hospital in an agreed period preceding the drafting of the HPPA.

The Interim Discussion Paper suggests that these models of service delivery and their associated funding arrangements should be judged on the following criteria.

1. The effectiveness with which the needs of consumers and their carers are met.
2. The efficiency with which the required services are able to be delivered.
3. The extent to which financial risk is equitably shared between providers and payers, or is controlled by other mechanisms.

The Discussion Paper acknowledges that health funds and other payers are not able to fund all the services that it may be desirable to have available. The Paper suggests that the models of service delivery that clearly require increased expenditure by payers should also meet the following additional criteria.

4. The disease, syndrome or condition for which services are to be delivered should be a recognised psychiatric condition.
5. The proposed model of service delivery and its constituent therapeutic interventions should be based on evidence that they represent current best– practice.

Copies of the Interim Discussion Paper can be obtained from the SPGPPS website at: http://www.spgpps.com.au/documents/spgpps/publications/IMWG_Discussion_Paper.pdf

Mr Phillip Taylor is SPGPPS Executive Officer and Chairs the IMWG.

Pilot of a Consumer Perceptions of Care (CPoC) Measure

Ms Janne McMahon

In September 2004, consumers in the private sector expressed the view that whilst satisfaction surveys were carried out by hospitals as part of their quality improvement processes, these seemed to lack consistency across the private hospital sector in their design and collection. At the National Mental Health Information Priorities Workshop, held in February 2004, there was strong agreement among all participants that the development and implementation of a nationally agreed measure of Consumer Perceptions of Care (CPoC) was a priority.

Project Development

Following these two developments and to progress this issue, the SPGPPS Information Strategy Working Group (ISWG) prepared a Project Brief in late 2004 that set out a plan for the evaluation and possible trial of the NRI/MHSIP Inpatient Consumer Survey, developed under the auspices of the Mental Health Statistics Improvement Program (MHSIP) and the National Research Institute (NRI) of the National Association of State Mental Health Program Directors. These measures are in the public domain.

The NRI/MHSIP Inpatient Consumer Survey, was referred by the ISWG to the National Network of Private Psychiatric Sector Consumers and their Carers (National Network), and the APHA Psychiatric Sub-committee for consideration and advice.

Following further consultation, a funding proposal was developed for a pilot study and evaluation of the feasibility and utility of the routine ascertainment and reporting of information regarding consumer perceptions of care in both private hospital-based and public sector specialist mental health services.

Issues to be addressed by the Pilot and Evaluation

The pilot aims to assess the following.

Validity and appropriateness of the measure from the consumer's and service provider's perspectives

1. Does it cover the domains of, for example, the rating of consumers' perceptions of the outcomes, quality of care provided the facility, attitudes towards consumers displayed by the hospital's or the service's clinical staff, quality and accessibility of the hospital or service environment and address the processes of care: admission process, discharge planning, provision of information?
2. Are the various domains covered by the measure relevant to consumers and able to be reported in an informative manner?
3. Is the measure sufficiently easy to complete?
4. Are there issues about the cultural appropriateness of this overseas measure for use in Australia and the appropriateness of this measure, initially designed for public sector services and agencies, for the private hospital sector in Australia?

Utility of the measure and the measurement process from the service provider's perspective

With service providers, the following issues are relevant in addition to those identified above.

5. Will the collection of these measures help providers to improve their services? In particular can summary scores be derived that are relevant to specific domains and is it possible to design meaningful reports? Further, can the reporting process be made sufficiently quick and frequent that routine collection of the measure is justified?
6. How will the collection of the measures interact with other questionnaires currently in use?
7. Could the reporting process be integrated within the existing CDMS or similar public sector processes?
8. What would be the likely annual cost should the collection and reporting process be fully implemented?

CPoC Ascertainment and Reporting Protocol

The pilot study will involve a test of a particular methodology for the ascertainment and reporting of CPoC over a period of sixteen weeks, allowing for three monthly reports, which will also enable the reporting framework to be refined during the course of the pilot.

Participants

In the private sector, at least six private hospitals with psychiatric beds have indicated that they wish to participate in the proposed study.

In the public sector, the Mental Health Unit of Queensland Health has indicated that they have identified a number of integrated mental health services that wish to participate and have the capacity to effectively do so.

Funding Agreement

The Department of Health and Ageing (DoHA) and Queensland Health have given "in principle" approval to the funding of the pilot, and an Agreement is in the process of being drafted.

Ms Janne McMahon is the Consumer representative on the SPGPPS and Chair of the National Network of Private Psychiatric Sector Consumers and Carers

Our Apollo 13 - Exploring Collaboration between SPGPPS and Universities

Dr Andrew Page

In the film *Apollo 13*, the astronauts need to re-enter the earth's atmosphere without exhausting the remaining electrical power. The solution requires NASA scientists to research ways to address the problems so the astronauts can return safely. As such, the film is a testimony to collaboration.

In a similar way, the Strategic Planning Group for Private Psychiatric Services (SPGPPS) was brought together to facilitate collaboration on issues relevant to the provision of mental health care in the private sector. Thus, there was an explicit recognition that coordinated action between alliance partners could achieve what none alone could attain.

Apollo 13 represents one model whereby universities and groups like the SPGPPS can collaborate to generate new knowledge. The astronauts were the ones working on the job. They faced the problems and they needed the solution. The NASA researchers were given the problem and asked to find an effective solution. Analogous to the astronauts, the SPGPPS members face the problems. Daily their members confront the difficult task of effectively and efficiently treating people with mental health problems. Universities, however, are analogous to the NASA scientists. University staff are not responsible for health care, but they are charged with the responsibility of finding novel solutions when the call goes out, "Houston, we've got a problem". Thus, collaboration between universities and the SPGPPS can be mutually beneficial.

An example of one such partnership is between staff at the University of Western Australia and Perth Clinic. Clinic staff describe issues they face in their work and solutions are explored within the framework of the academic collaboration. For instance, staff wondered if it was possible to identify potential treatment drop-outs sufficiently early to implement a remedial program. We researched the topic and found that drop-outs could be identified and implemented a program to try to address the issues. Second, Perth Clinic and its benchmarking hospitals wondered about the stresses and strains borne by the supporters of inpatients, therefore we conducted an assessment of the extent of the burden with a view to better targeting resources to address the needs of supporters. Third, staff wondered when it would be best to time reviews of an inpatient's stay in hospital. It was possible to identify ways to schedule reviews so that they were most efficient with respect to the treating psychiatrists' scarce time. Finally, the data from the SPGPPS Centralised Data Management Service (CDMS) provides a rich source of information on the one hand, but it poses serious questions for each hospital on the other. For instance, each hospital will be able to identify strengths and weaknesses from the data, but this poses the question, "How best to capitalise on strengths and address weaknesses?" In collaboration, we have been able to identify areas where new treatment strategies may be needed. This collaboration has involved a link between academics and postgraduate students in the university and clinic staff. These collaborations have not only benefited hospitals and their patients, since data have been used for continuous quality improvement, but they have been beneficial to the university, since outcomes have been published in peer-reviewed journals (see below) and supported numerous postgraduate theses. In so doing, the bringing together of academic and hospital staff creates a culture of excitement about a more research-informed and research-informing clinical practice.

Thus, SPGPPS is in a strong position to develop links with the tertiary educational sector and derive comparable benefits. The tertiary sector aims to generate new knowledge and can bring to bear the resources it has to achieve this end. Likewise, generating new knowledge is part of the SPGPPS strategic plan. Collaboration between the SPGPPS, its member hospitals, and key staff within universities can serve to achieve outcomes that neither could have attained alone.

Recent Collaborative UWA-Perth Clinic Research Publications

Hooke, G. R., & Page, A. C. (2002). Predicting outcomes of group cognitive behaviour therapy for patients with affective and neurotic disorders. Behavior Modification, 26, 648-659.

Page, A. C., & Hooke, G. R. (2003). Outcomes for depressed and anxious inpatients discharged before or after group cognitive behaviour therapy: A naturalistic comparison. The Journal of Nervous and Mental Disease, 191, 653-659.

Page, A. C., Hooke, G. R. (2004). Failure to replicate effects of gender and season on length of hospitalisation in unipolar depressives. Journal of Affective Disorders, 81, 275-278.

Page, A. C., Hooke, G. R., & Rampono, J. (2005). A methodology for timing reviews of inpatient hospital stay. Australian and New Zealand Journal of Psychiatry, 39, 198-201.

Page, A. C., Hooke, G. R., & Rutherford, E. M. (2000). Measuring mental health outcomes in a private psychiatric clinic: Health of the Nation Outcome Scales and Medical Outcomes Short Form SF-36. Australian and New Zealand Journal of Psychiatry, 35, 377-381.

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