

News

Issue 16 | November 2003

Australian Medical
Association

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The Royal Australian
and New Zealand
College of Psychiatrists

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The Royal Australian
College of General
Practitioners

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Commonwealth
Department of Health
and Ageing

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Department of Veterans'
Affairs

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Mental Health
Consumers and Carers

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Australian Private
Hospitals Association

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Australian Health
Insurance Commission

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- **Substance Abuse and Dependency**

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SPGPPS News provides a brief summary of some of the issues being progressed under the auspice of the SPGPPS process. 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 view of participating organisations, unless otherwise stated. Further information can be obtained from the SPGPPS Website at www.spgpps.com, or by contacting the Secretariat on 02 6270 5438.

Editor's Desk

Dr Bill Pring

The AMA, RANZCP, APHA, AHIA and the Australian Government have agreed to the continuation of the SPGPPS, its CDMS and National Network under an overarching *AMA Agreement for SPGPPS Services*, for the period of three calendar years from 1 January 2004 to 31 December 2006. Having all of the activities of the SPGPPS under the umbrella of one agreement will simplify accounting practices and will no doubt be the cause of much rejoicing in the AMA Finance Department.

Centralised Data Management Service (CDMS)

The CDMS is currently preparing the quarterly reports for Hospitals and Health Funds for the second quarter of 2003. Mr Allen Morris-Yates, SPGPPS Principal Information Officer estimates that there is a minimum lag time of thirteen weeks between the end of a data collection quarter and the generation of Reports. This series of reports will contain comparative data for the last financial year.

The CDMS has also been approached by an organisation, operating private sector mental health services in an ambulatory care setting. This presents some interesting challenges, notably in how to estimate a realistic subscription rate for organisations without psychiatric beds. Allen discusses some of the options in his article in this Issue.

National Network

Our National Network of Private Sector Psychiatric Consumers and Carers held its Second (2nd) Meeting and a Workshop on 18/19 August 2003 at RANZCP Headquarters in Melbourne. Ms Elizabeth Morgan, of Morgan Disney and Associates, was commissioned by the National Network to facilitate the Workshop on the second day. The highly successful meeting produced a number of outcomes, which are detailed by Janne McMahon in this Issue of SPGPPS News.

Outreach Services

The SPGPPS has adopted a set of *General Principles and Recommendations*, to encourage the uptake of innovative models of service delivery and enhance co-ordination of care between GPs, psychiatrists and hospitals. The SPGPPS Innovative Models Working Group is in the process of progressing these, our Executive Officer, Phillip Taylor updates us on the current state of play with the uptake of Outreach Services.

National Standards for Mental Health Services

The situation, with regard to the incorporation of the National Standards for Mental Health Services into the accreditation of private psychiatric hospitals, is that while this level of accreditation has been part of public

hospital accreditation for several years it has been considered an add-on for private hospital accreditation. The crux of the current problem is that while the Australian Council on Healthcare Standards can conduct assessments of mental health services against the National Standards, there is a considerable extra cost involved for private hospitals. Ms Moira Munro delves deeper into the problem in this edition.

Workforce and the IBNR Levy

Ensuring private sector mental health services are supported by a high quality workforce will be a difficult goal to achieve, given the decrease in workforce participation rates in the health professions generally, and the increasing unaffordability and unsustainability of specialist medical training and practice. The problems of workforce sustainability are particularly acute with the proposed introduction of the IBNR levy.

Doctors met in Sydney on 28 September 2003 to protest the imposition of the Levy and our Chair, Dr Yvonne White, wearing her psychiatrists hat gave a short address on the effect of the Levy on psychiatrists in private practice. Though the impact on psychiatrists is much less than say obstetricians, Dr White asserts that the opportunities to reduce the added burden are much less in psychiatric practice as well.

Substance Abuse and Dependency

The SPGPPS believes that substance abuse and dependency is a major social problem and a significant issue for the private sector. We have therefore put in place a Working Group to look at the issue and develop a *SPGPPS Substance Abuse and Dependency Project Brief*. Mr David Morton of the Department of Veterans' Affairs (DVA) will Chair the Working Group. David has been intimately involved in the DVA initiative *The Right Mix – Your Health and Alcohol* and talks about this initiative in this Issue.

Privacy Kit for Mental Health Service Providers

Members of the Mental Health Privacy Coalition met with the Federal Privacy Commissioner, Mr Malcolm Crompton in Sydney on 22 October to consider the final draft of the Kit. This gave the Commissioner an opportunity to discuss the further concerns his Office has with the Kit. The Kit is undergoing further revision and will be sent back to the Office of the Federal Privacy Commissioner for consideration when that process is completed.

Dr Bill Pring
Editor

SPGPPS Centralised Data Management Service

Mr Allen Morris-Yates

As readers will know, the SPGPPS is responsible for oversight of the operation of the *SPGPPS National Model for the Collection and Analysis of a Minimum Data Set with Outcome Measures for Private Hospital-based Psychiatric Services* (hereafter National Model) and its Centralised Data Management Service (CDMS).

Approximately 40 private hospitals with psychiatric beds (Hospitals), representing 95% of the industry, are participating.

These Hospitals are collecting two standardised measures of clinical status, one clinician-completed rating scale (HoNOS) and one patient-completed questionnaire (SF14M), at admission and discharge from episodes of care.

Together with data collected under the Hospital Casemix Protocol (HCP), the information regarding patients' clinical status is used in the generation of aggregate statistics regarding Hospitals' workload (casemix) and the outcomes of the care provided.

Current Status

As at 30 October, 2003, Hospitals and Health Funds will have received the Quarterly Reports from the CDMS for the second quarter of 2003.

These reports also contain the comparative data on an annual basis, as this quarter represents the end of data collection for the last financial year.

The CDMS also provides reports to the SPGPPS that contains key aggregated de-identified statistical findings on private hospital-based psychiatric services at the national level.

New Hospitals

Since May 2003, we have welcomed a further three Hospitals to the CDMS program.

- *Greenslopes Private Hospital*, in Brisbane
- *Pine Rivers Private Hospital*, in Brisbane
- *Sunshine Coast Private Hospital*, in Buderim

The first round of visits to train their staff in data collection and the use of the CDMS software was conducted in early October.

Participation in the SPGPPS CDMS by private psychiatric services without beds

The SPGPPS has been approached by an organisation, operating private sector mental health services in an ambulatory care setting.

These services have expressed strong interest in participating in the SPGPPS's CDMS. It is known that there are a number of similar services being run elsewhere.

At the last meeting of the SPGPPS, representatives strongly endorsed the involvement of such services in the SPGPPS and its CDMS.

However, as these are not bed-based services, the question arises as to how their subscription fee should be calculated, an issue which is currently being addressed by the APHA in consultation with the interested services.

These and other considerations must be carefully assessed by the APHA before the services of the CDMS can become available to ambulatory services in the private psychiatric sector.

Mr Allen Morris-Yates is the SPGPPS Principal Information Officer.

The National Network

Ms Janne McMahon

With funding from the AMA, RANZCP, Beyondblue, and now the APHA, the activities of the National Network of Private Psychiatric Sector Consumers and Carers (National Network) has been placed on a firmer footing.

The National Network held its Second (2nd) Meeting and a Workshop on 18/19 August 2003 at RANZCP Headquarters in Melbourne. Ms Elizabeth Morgan, of Morgan Disney and Associates, was commissioned by the National Network to facilitate the Workshop on the second day. The 2nd Meeting and Workshop set out to define the nature, structure and projected activities of the National Network. The focus was to develop an underlying philosophy and plan for the Network, summarised below in the Vision Statement and Terms of Reference.

Vision Statement

The National Network for Private Psychiatric Sector Consumers and Carers is dedicated to effective consumer and carer participation as the driving force in all elements of change in private sector mental health services.

Terms of Reference

1. *To provide formal infrastructure support and a clear mechanism to enable the Strategic Planning Group for Private Psychiatric Services' (SPGPPS) consumer and carer representatives to obtain informed advice from, and consult with, their constituency concerning the design, delivery and evaluation of private sector mental health services.*
2. *To develop an expanded constituency of consumers, carers and other interested parties to support and advise the National Network on issues, which affect mental health consumers and carers in the private sector, particularly in relation to issues of national significance.*
3. *To develop mechanisms and linkages for National Network State and Territory Co-ordinators to liaise with private hospital consumer and carer advisory committees, or their consumer consultants, and other State and Territory based organisations and networks involved in mental health care services.*
4. *To encourage the development of consumer and carer advisory committees in private sector provider and funder organisations.*
5. *To encourage the provision of more inclusive practices for people who receive their treatment and care from office-based practitioners.*
6. *To provide a point of reference and a mechanism for consumer and carer nomination,*

participation and advice to organisations, committees and working groups requiring private sector input including, but not limited to, the following.

- *The Royal Australian and New Zealand College of Psychiatrists*
 - *The Private Practitioners Network*
 - *The Royal Australian College of General Practitioners*
 - *The Australian Divisions of General Practice*
 - *The Australian Psychological Association*
 - *The Australian Private Hospitals Association*
 - *The Australian Health Insurance Association*
 - *Australian Government*
 - *The Australian Council on Health Care Standards*
 - *The Mental Health Council of Australia*
 - *Education and training authorities*
 - *Other professional bodies*
7. *to develop and implement processes to enable the evaluation of the responsiveness and accountability of private sector stakeholders to the rights and needs of consumers and carers.*
 8. *To be the authoritative voice concerning the policy and practices of provider and funder organisations as they affect consumers and carers using private sector mental health services.*
 9. *To improve mechanisms for the handling of complaints and adverse events in private sector mental health services.*
 10. *To explore the feasibility and legal requirements of a self-funding model for the National Network.*

State and ACT Coordinators

The Network's State and ACT Co-ordinators listed below are in the process of establishing State and Territory Committees. It is anticipated that their first meetings will be held by the end of this year.

- | | |
|---------------------------------|---------------------|
| 1. Queensland | Ms Julie Hutson |
| 2. New South Wales | Ms Alvina Hill |
| 3. Victoria | Mr Wayne Chamley |
| 4. South Australia | Ms Majorie Smith |
| 5. Tasmania | Mr Trevor Bester |
| 6. Western Australia | Mr Patrick Hardwick |
| 7. Australian Capital Territory | Ms Kim Werner |

Ms Janne McMahon represents Consumers on the SPGPPS and chairs the National Network.

Outreach Services in the Private Sector

Mr Phillip Taylor

Readers will recall that, earlier this year, the SPGPPS endorsed and adopted a set of *General Principles and Recommendations*, to encourage the uptake of innovative models of service delivery and enhance co-ordination of care between GPs, psychiatrists and hospitals.

Service Innovation

Innovation in this context means, evidence-based services that are not yet available locally, not yet sufficiently utilised, or for which appropriate funding arrangements do not yet exist. The SPGPPS is supportive of innovative services that result in the improvement, or at the very least maintenance, of the quality of patient care.

Implementation of these services should result in an increase, or at the very least maintenance, of the overall cost-effectiveness of service provision. Any proposed model of service delivery should be based on best available evidence and represent best practice.

Outreach Services

The SPGPPS has also supported the substitution of overnight admitted patient care with less restrictive models of care. In doing so, the SPGPPS has recommended that, private hospitals with psychiatric beds and health funders jointly commit to a change process, involving the sharing of both risks and cost benefits, so that Hospitals are able to implement **approved outreach services** to deliver improved cost effective mental health care to consumers and their carers in the private sector.

Psychiatrists have been asked to support this change process through their local Medical Advisory Committees, the RANZCP and the AMA.

Current State of Play

This update is kindly provided by the Aged Interface Section of the Acute Care Division of the Australian Government's Department of Health and Ageing.

To date there are 19 services approved, encompassing 30 hospitals, and over half are psychiatric services (10 of the 19). We have 17 psychiatric hospitals providing acute care to admitted patients in their own home. A new psychiatric outreach service was recently approved to commence on 1 November 2003.

In an outreach service, such as Hospital in the Home, patients are admitted to the hospital. However, they are able to reside within their own home, under the care of a treating hospital doctor and the hospital's multidisciplinary team.

The many benefits of this model of care include increased patient satisfaction; reduced demand for

hospital beds; reduced lengths of stay; and reduced costs for both patients and health insurance funds. Health care professionals (involved in referral and/or treatment), as well as most patients and their carers, are enthusiastic about the services.

The services are effective for a wide range of patients in different circumstances, including longer term conditions such as psychiatric.

In the past, outreach programs were largely restricted to public patients in public hospitals, as provisions within the *National Health Act, 1953* (the Act) provided a barrier to such programs in the private sector. On the successful conclusion of the trials, the Act was amended, enabling health funds to finance outreach services as a direct substitute to in-hospital care for admitted patients from their hospital tables.

In June 2003 the basic default benefit for outreach services was increased to \$150. The default benefit is payable by the health insurance fund for treatment of a patient by an approved outreach service, where a contract has not been negotiated with the patient's fund.

Under the legislation, hospitals and funds seeking to offer outreach services must first obtain approval from the Australian Government Minister for Health and Ageing. On approval, health funds are able to pay benefits for these services from their hospital tables.

Seeking Approval for Outreach Services

To obtain Ministerial approval for outreach services hospitals must satisfy a number of guidelines. These were developed in consultation with stakeholders and are available on the Department's website, along with the application form. The Private Sector Outreach Services Working Party consider applications and provide recommendations of approval to the Minister's Delegate. To view the guidelines and application form visit:

Guidelines:

<http://www.health.gov.au/privatehealth/providers/circulars01-02/index.htm>

Application form:

www.health.gov.au/privatehealth/providers/forms/index.htm

Readers who wish to discuss the approval process should contact Ms Julie Marr on 02 6289 6829.

SPGPPS General Principles and Recommendations

<http://www.spgpps.com/>

Mr Phillip Taylor is the Executive Officer of the SPGPPS

National Standards for Mental Health Services

Ms Moira Munro

Private hospitals with psychiatric beds strive to excel in all aspects of quality care and seek Accreditation through approved Accreditation authorities in Australia.

National Standards for Mental Health Services

The situation, with regard to the incorporation of the National Standards for Mental Health Services (National Standards) into the accreditation of private psychiatric hospitals, is that this issue has been in the public arena for several years.

Although accreditation of private psychiatric hospitals against the National Standards is voluntary, the expectations of the Australian Government, and of funders, is that private hospitals will seek accreditation against the National Standards, which if not now, then in the future, will render them effectively mandatory.

For example, the current draft revision for *Guidelines Determining Benefits for Health Insurance Purposes for Private Patient Hospital-based Mental Health Care* includes references to the National Standards.

As the National Standards have now become the accepted benchmark, private psychiatric hospitals are keen to demonstrate that they meet these standards.

The Crux of The Problem

Unfortunately, while the Australian Council on Healthcare Standards (ACHS) conducts assessments of mental health services against the National Standards, there is a considerable extra cost involved for private hospitals. In the public sector, extra funding is provided under the Australian Health Care Agreements. The private sector, however, is not covered under this arrangement and accreditation surveys, including assessment against the National Standards, cost facilities a minimum of \$1,500 extra. This additional cost is a result of the need for a consumer surveyor to be part of the survey team.

Unlike the public sector, where mental health services are usually provided by hospitals as just one of several services, most of the mental health facilities in the private sector are relatively small, stand-alone psychiatric hospitals. Therefore, they

often decide a separate “add on” accreditation survey is just too much of a burden. While private hospitals welcome consumer surveyors, we have consistently asked that those surveyors have experience of being treated in the private sector. To date, only one private sector consumer surveyor has been recruited by ACHS.

The Australian Private Hospitals Association has been negotiating these issues with ACHS for several years now. As yet a solution has not been found.

This impasse means that few, if any, private psychiatric hospitals are accredited against the National Standards, although most have met the requirements of standard ACHS accreditation. It is the costs involved and the inability to recruit consumer surveyors that has led to this situation, rather than any inability on the part of private facilities to meet the Standards.

An Integrated Accreditation Product

What we need is an affordable and integrated accreditation product rather than accreditation against the National Standards as an ‘add-on’. This should be achievable, given that the ACHS has always sought to spread the cost of accreditation surveys across all hospitals to ensure that no hospital bears an increased burden due to location, size etc. Hospitals want to be assessed against the National Standards but the current costs effectively discriminate against these hospitals through the imposition of the additional charge.

The Way Forward

On 17 November 2003, the SPGPPS facilitated a meeting to discuss these issues with the Executive Officer of the ACHS, Mr Brian Johnson. The following representatives attended that meeting.

Dr Yvonne White (Chair SPGPPS)
Ms Moira Munro (Hospitals)
Ms Darlene Hennessy (Health Funds)
Ms Janne McMahon (Chair National Network)
Mr Paul Mackey (APHA)
Mr Phillip Taylor (Executive Officer SPGPPS)

I will be informing the sector on the outcome of that meeting in the next edition of *SPGPPS News*.

Ms Moira Munro represents all private hospitals with psychiatric beds on the SPGPPS

Workforce and IBNR Levy

A Psychiatrist's Perspective

Dr Yvonne White

Ensuring private sector mental health services are supported by a high quality workforce will be a difficult goal to achieve, given the decrease in workforce participation rates in the health professions generally, and the increasing unaffordability and unsustainability of specialist medical training and practice. The problems of workforce sustainability are particularly acute with the proposed introduction of the IBNR levy.

Background

The government announced the new framework on medical indemnity on 23 October 2002. The purpose of this new framework is to address rising medical indemnity insurance premiums and ensure a viable and ongoing medical indemnity insurance market. The new framework was enacted by the Parliament in 2002 under the Medical Indemnity Act 2002 ("the Act"). The Incurred But Not Reported Liabilities (IBNR) Scheme ("the IBNR Scheme") is one of the elements of this framework.

- Under the IBNR Scheme, the government is funding the IBNR liabilities for those Medical Defence Organisations (MDOs) that have not set aside money to cover these liabilities, and recouping the cost of that funding through contributions by their members payable over an extended period.

IBNR Rally – the View from Private Psychiatric Practice

Doctors were invited to attend the rally held in Sydney on 28 September 2003 and I gave the following short speech from the perspective of psychiatrists.

"I am a psychiatrist in full time private practice, but doing one VMO session a week, my contract being for 7 hours per month.

While I was involved in the Relative Value Study negotiations with the Commonwealth Government, it became very apparent to me that we were one of the lowest income specialists – no doubt because we see patients for ½ hour or 1 hour consultations, mainly, therefore, limiting the number of patients we see per day and also any possibility of increasing our incomes to cope with unexpected increased costs such as levies and calls.

Currently, our subscription for UMP consists of membership (\$962.50) and AMIL (\$11,626.39), which comes to a total of \$12, 588.89 – quite high

for a specialty, which has only one procedure, ECT, which is performed by very few, very infrequently. The call has been \$1491.38. Now we also have the IBNR levy of \$3443.50 for the next 10 years.

I personally had not intended working for the next 10 years, and if I did, it would be for greatly reduced hours., but this does not influence my costs as I must earn less than \$5000 per year to be exempt from the IBNR levy.

My Concerns

My concerns about the IBNR are as follows.

1. There is no guarantee the amount will not rise, even though the brochure says the period will never be more than 10 years.
2. The legislation does not allow for money to be returned to the doctors if the Government raises the required amount in 2 years.
3. There is also nothing to assure us that they will not keep collecting the levy unnecessarily and putting it into consolidated revenue.

Under these circumstances, why would anyone pay the lump sum? Colleagues have contacted me saying they are only doing one session of private practice per week, the rest being in the public system, and by the time they pay their UMP subscription, the call, the levy and taxes, there is nothing left.

Others are deciding to retire altogether because they earn greater than \$5000, in one case only \$20,000 per year, but all this will go on the UMP subscription, the call, the levy, rent and taxes.

At a time when workforce is a critical issue in mental health, we cannot afford to be losing practitioners, especially those with experience and expertise, who educate our junior fellows.

I personally object to being made to pay for other's negligence, namely APRA, the Commonwealth Government and UMP management. If APRA had been doing its job, HIH would not have collapsed and UMP would not have had to write off \$35 million. Further, UMP would have been pulled up earlier and the situation rectified to a major degree.

However, we still need Government funding for supporting care of those who are seriously injured and disabled. The mentally ill are suffering the most as they are most vulnerable and stigmatized."

Dr Yvonne White - psychiatrist in private practice

Substance Abuse and Dependency

Mr David Morton

The SPGPPS has agreed that substance abuse and dependency is a major issue for private sector mental health services and referred this matter to its Innovative Models Working Group (IMWG). The IMWG subsequently investigated the issues involved with the current treatment and care of substance abuse and dependency, in respect of both alcohol and other drugs, in the private sector, particularly in relation to:

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

The IMWG has advised the SPGPPS that determining the current treatment and care of substance abuse and dependency in the private sector would be a complex and potentially costly task. Additional specialist expertise in the area of the treatment of substance abuse and dependency would also be required and the work would take approximately 12-18 months to complete.

The SPGPPS has agreed to proceed with this work and a small Substance Abuse and Dependency Working Group (SADWG) will be advising on the development of an SPGPPS *Substance Abuse and Dependency Project Brief*. The first meeting of the SADWG will be held shortly.

In the interim, I would like to provide for readers the following information on the Department of Veterans Affairs *The Right Mix* initiative.

DVA Alcohol Management Project (AMP) - Our Goal

To increase awareness and strengthen services to create opportunities to reduce alcohol related harm in the veteran community. Project activities are directed towards ensuring that alcohol and related problems are addressed in an integrated way with other physical and mental health conditions and encompass prevention, early intervention, treatment and relapse prevention.

AMP was created as a response to alcohol and substance abuse disorders and related problems in the veteran community, as identified in the Vietnam Veterans Morbidity Study (1998) and the Department of Veterans' Affairs (DVA) mental health policy. The project is being developed in the context of the National Alcohol Strategy.

Key Guiding Principles

- Harm reduction

- Evidence based practice
- Shared responsibility and partnership
- Creating a Best Fit between client need & intervention

AMP has been developed with the input of consultative committees made up of experts on alcohol, health and veterans.

Partnerships

AMP is a partnership of ex-service and veteran community organisations and DVA and is endorsed through a Partnership Agreement. The project builds on existing initiatives already in place in the veteran community.

AMP also maintains active partnerships with a number of organisations outside DVA including:

- Department of Health and Ageing;
- Department of Defence; and
- Australian Centre for Posttraumatic Stress Disorder and Mental Health (ACPMH).

Increasing Awareness - Health Promotion and Communication

The Right Mix: Your Health and Alcohol is the project's health promotion program and aims to increase awareness and knowledge, and influence attitudes and behaviour. It promotes a 'self help' approach to taking action, using existing and strengthened health services. *The Right Mix* is guided by a communication strategy with a look, messages, products and communication avenues that 'hit the mark' with the veteran community and health providers. It resonates with veterans and health providers alike because it is based on market research conducted with these groups.

The Right Mix Information Kit

A comprehensive information kit was developed that educates in a relevant, informative and up-to-date way. Each kit includes a range of products to meet the different needs of people in the veteran community, from a brochure to a self-help guide to changing your drinking. The products can be used on their own or together with individuals or groups. Copies were distributed to the veteran community, DVA registered health providers, Vietnam Veterans Counselling Service (VVCS) and drug and alcohol agencies that work with veterans, supported by articles in DVA, veteran and health provider publications. Orders for materials remain steady.

Website

A website www.therightmix.gov.au supports and complements these materials, acting as both as a source of information and a step towards 'taking action'. It features an interactive self-assessment tool by which visitors can assess their drinking patterns, as

well as get feedback on whether they are ready to change their drinking behaviour. Visitors can order materials online and subscribe to a regular bi-monthly website newsletter, *Today's Mix*, to stay up to date with health and alcohol issues. The home page has different 'help' buttons - help yourself/ help your partner/ help your mate/ help a client or patient - allowing visitors to quickly find the information most relevant to them. *The Right Mix* website icon has been provided to veteran community organisations and peak bodies to create a link on their sites. Placing the link on their sites has had an immediate positive impact on the number of visitors to www.therightmix.gov.au.

Getting the Message Out

The targeted distribution strategy has been supported by workshops to help people make best use of the materials and identify local strategies to 'get the message out'. Workshops held with veteran networks, VVCS, health providers and DVA Community Advisers have helped veterans and providers find ways to integrate *The Right Mix* into their health promotion and community development activities.

Articles and announcements in DVA, veteran community and health provider publications have proved an important support for the distribution and workshops by further promoting *The Right Mix* with target audiences. Articles are distributed to newsletter editors on a regular basis and highlight the key messages from the communication strategy. To date, articles have featured *The Right Mix* information package; the website; alcohol and medications; a 'self-help' approach to changing your drinking; alcohol and

ageing; and some positive stories about participants who are managing to change their drinking through the self-help correspondence program (see below). Veteran community newsletter editors have demonstrated strong support by publishing articles and some are now themselves contacting the AMP team for material as publication deadlines approach.

Strengthening Services

Pathways to Care Conference (November 2001)

This conference helped to set the overall directions for the project. Participants included DVA, health providers, alcohol and drug experts and the veteran community. Outcomes emphasised the importance of having a health promotion strategy to deliver effective messages, developing opportunities for improved screening and brief intervention, and strengthening treatment services through the development of treatment practice guidelines relevant to veterans.

Alcohol Screening and Brief Intervention (AS+BI)

AS+BI is being promoted as a best practice approach to early detection and intervention of alcohol related harm in the veteran community.

As part of this the AMP team has:

- Written a training manual for health providers;

- Conducted a national training program for VVCS staff and counsellors who are now conducting alcohol screening with all new clients;
- Trialled the use of AUDIT as a screening tool in the VVCS; and
- Completed a trial to introduce AS+BI as a standard protocol in Community Nurse DVA assessments.

Evaluation of the Community Nursing project has started and early figures indicate that 493 community nursing clients were screened and 6 per cent were detected as risky or high-risk drinkers. The majority of clients were fully cooperative with the process and community nurses taking part in the trial generally agreed that alcohol screening should be part of routine assessments.

Changing the Mix - Self-Help Correspondence Program

This is aimed at veterans, peacekeepers and defence force personnel who would like to do something about their drinking. Interested people call a 1800 number, enrol in the ten-week confidential program and receive information and material to work through. It is not a counselling service but a new treatment option based on proven methods developed by the University of Queensland.

At the end of October 2003, over 50 people had signed up, including 12 from the Australian Defence Force (ADF). 13 have completed the program and early results

indicate that their drinking has dropped from an average of 50 standard drinks a

week to approximately 20. Participants have commended the program for its private nature and the fact that it can be done in their own time. The program is being conducted in partnership with DVA, ADF and the University of Queensland.

Practice Guidelines for Alcohol Treatment for Veterans

Encouraging evidence-based practice amongst service providers and treatment programs is important. Through a partnership with the ACPMH we are developing *Practice Guidelines for Alcohol Treatment for Veterans* that will strengthen service provision and assist DVA in knowing what programs to purchase for veterans and their families. Guideline topics are:

- Screening and assessment
- Withdrawal and detox
- Problem drinking
- Relapse prevention
- Alcohol and PTSD treatment

Evaluation of the draft Guidelines is almost finished and a series of demonstration projects will test them in the field.

Mr David Morton represents DVA on the SPGPPS, is the Project Manager of DVA's Alcohol Management Program and Chairs the SADWG

How to Contact Your Representatives

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