

STRATEGIC PLANNING GROUP FOR
SPGPPS
PRIVATE PSYCHIATRIC SERVICES

News

Issue 18 & 19, July 2004

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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

This edition *SPGPPS News* constitutes Issues 18 and 19 and spans activity for both the second and third quarters of 2004.

The last (36th) SPGPPS Meeting was hosted by the New Farm Clinic in Brisbane on Friday, 11 June 2004 at the kind invitation of New Farm's CEO, Ms Sue Feeney. Most of the issues discussed at that meeting are being progressed either directly or indirectly by an SPGPPS working group.

Substance Abuse & Dependency Working Group (SDWG)

This Working Group is looking at the complex issues involved in the current treatment and care of substance abuse and dependency, in respect of alcohol and other drugs, in the private sector, and the issue of the comorbidities involved.

To further this objective, SDWG arranged for Ms Fiona Shand to present at the last meeting of the SPGPPS on the National Drug and Alcohol Research Centre's (NDARC) *National guidelines for treating alcohol problems* project. Details of the project and further resources are given in this edition.

Innovative Models Working Group (IMWG)

The SPGPPS has reconvened IMWG and amended its terms of reference to enable it to further explore different models of funding and service delivery that have some demonstrated potential to make a change for the better. As a first step toward informing that work our SPGPPS Health Fund Representative, Mr Brian Osborne, provided an excellent presentation at the last meeting of the SPGPPS on alternative models of funding. Brian further enlightens us in this edition of *SPGPPS News*.

The next step is for our SPGPPS Consumer and Carer, Psychiatry, and Hospital, Representatives to inform us of their perspectives on innovative models of funding and service delivery. Presentations for the SPGPPS are currently being prepared by these stakeholders.

Information Strategy Working Group (ISWG)

Our ISWG is focussed on the complex task of improving the quality of information available to the private mental health sector and has developed a far-reaching work plan for the next two years. I have provided more details on the ISWG work plan in this edition.

National Network

Our National Network of Private Sector Psychiatric Consumers and Carers (National Network) will hold a face-to-face meeting on 23-24 August 2004 in Melbourne to develop a new work plan for the next 12 to 18 months. Readers will be interested in the Networks new Vision Statement, *Engage, empower,*

enable choice in private mental health. The Network produces its own newsletter, detailing its activities.

Towards Better Mental Health for the Veteran Community

The Repatriation Commission is proposing reforms to mental health care services for veterans. The proposed reforms will strengthen assessment, treatment and continuity of care and improve access to a broader range of mental health care for veterans. This will encourage providers to offer a better mix of hospital and community based mental health services and where clinically appropriate, use of community based alternatives to inpatient mental health services. Our DVA representative, Mr David Morton provides further information in this edition *SPGPPS News*.

Access to Psychiatric Beds

The SPGPPS is currently debating the issue of access to psychiatric beds in the private sector for people with private health insurance, particularly for those people living in rural and remote areas of Australia, and those who have been detained against their will.

Our Chair, Dr Yvonne White, has raised this issue with the AHMAC National Mental Health Working Group (NMHWG) and written to State and Territory health authorities to ascertain their policies and legislation concerning the certification of private Hospitals. We need to know what the barriers are to changing existing practices with regard to private hospitals being able to take involuntary patients.

Public and Private Sector Integration

Another issue the SPGPPS is progressing with the NMHWG is how we can work together to achieve better integration between the private and public sectors, particularly in relation to general policies and/or protocols on.

- communication between the public sector and the private sector including general practice, particularly in relation to the provision of feedback from the public sector to the private sector after an episode of care; and
- utilisation of private sector beds when "bed overflow" occurs in the public sector.

Name Change for the SPGPPS

The next (37th) SPGPPS Meeting will debate changing our title from SPGPPS to *Private Mental Health Alliance*. SPGPPS has agreed that any name change will have to capture the concepts of alliance, partnership and mental health.

The next (37th) SPGPPS Meeting will be hosted by the Perth Clinic on Friday 10 September 2004.

Dr Bill Pring - Editor

NDARC Guidelines for Treating Alcohol Problems

Ms Fiona Shand

The National Drug and Alcohol Research Centre's (NDARC) *National guidelines for treating alcohol problems* project commenced two and half years ago with funding from the Australian Government Department of Health and Ageing, and with input from an expert panel that included GPs, psychiatrists, and psychologists.

Development of the Guidelines

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

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

Content of the Guidelines

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

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

Advantages of Treatment Guidelines

The Guidelines serve as a central resource for clinicians and researchers and an evidence base for organisational and clinical decision making, education and training. Evidence-based treatment does not rule out individualised treatment or clinical judgement.

Arguments Against Having Treatment Guidelines

Arguments include a perception that guidelines try to override clinical expertise, the difficulty of

making recommendations where no evidence exists and the difficulties associated with translating research into clinical practice. There are also issues about liability and effective implementation and/or dissemination of the Guidelines

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

Implementation Project

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

Other Implementation Initiatives

NDARC has been asked to assess the need for a computerised decision support system based on the Guidelines. Workshops have been aimed at other health care sectors, e.g. nurses' teaching hospitals, practicing nurses, psychologists, and psychiatrists. NDARC has had some brief discussions with RANZCP. Another project (not involving NDARC and funded by AERF) is aimed at increasing GP intervention.

Resources

Alcohol related resources, including the Guidelines can be downloaded from

<http://www.health.gov.au/pubhlth/publicat/alcohol.htm>

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

Ms Fiona Shand is the Project Officer, for the National Drug and Alcohol Research Centre. NDARC may be contacted at j.stafford@unsw.edu.au.

Information Strategy Working Group

Dr Bill Pring

The SPGPPS established this Working Group to develop an information strategy for the private sector aimed at improving the quality, availability and utilisation of information regarding private sector mental health services. After several intensive meetings, the ISWG has developed the following Work Goals to guide its activities over the next two years.

Re-development of the SPGPPS website to better promote the work of the SPGPPS, CDMS, and the National Network of Private Psychiatric Sector Consumers and Carers.

As part of improving the availability of information to the private sector, the upgraded SPGPPS website will be on-line before the end of this year. The new look website will reflect the three strands of SPGPPS activities; SPGPPS, its CDMS and the National Network.

Ensuring that the current integrity and security of the SPGPPS National Model is maintained, as the various conceptual issues that underpin the Model change. These include:

- (a) *changes to the Hospital Casemix Protocol (HCP);*
- (b) *changes to the clinician rated (HoNOS) and consumer rated (MHQ-14) outcome measures currently in use;*
- (c) *changes in how data is collected, for example, on Day Only Patients; and*
- (d) *the development of protocols for aggregate statistical analyses that, rather than being based on episodes of care as the subjects of analysis, are based on each (unidentified) patient's combined history of episodes of care within a specified reporting period as the subjects of analysis.*

In relation to (a), the ISWG is looking at problems with the identification in the HCP of various types of ambulatory care, particularly in relation to the considerable variation that exists in the manner in which Hospitals record "Outreach Care". We want to know whether a change can be made to the HCP under current legislation to address this problem.

Under (b), readers will be interested to note that the SPGPPS Information Officer, Mr Allen Morris-Yates, has been provided access to the Australian Bureau of Statistics (ABS) Confidentialised Unit Record Files (CURF) to enable revision of the MHQ-14 Scoring Algorithms. This work will take about 60 days for Allen to complete.

To assist the ISWG in its review of the development of protocols for aggregate statistical analyses based on combined history of episodes of care, Mr Morris-Yates, will prepare a discussion paper in the second half of 2005.

Review of the current CDMS Quarterly Reports for Hospitals and Health Funds and provision of advice on any necessary changes

The ISWG, with the assistance of Mr Morris-Yates, will complete this Review in the first half of 2005.

Development of a framework for training and implementation support groups at the local level to ensure the sustainability and integrity of the SPGPPS National Model for the Collection and Analysis of a Minimum Data Set with Outcome Measures for Private, Hospital-based Psychiatric Services (hereafter, National Model).

There is evidence that this is already occurring. The Private Hospitals Association of Queensland, for example, hosted a Forum on 27 July 2004 titled, *Utilising CDMS Data for Clinical & Business Management: An Interactive Forum for Private Psychiatric Hospitals Managers*. The ISWG role will be one of encouraging such developments at the local level.

Review of the existing risk management strategies for the National Model and the SPGPPS's Centralised Data Management Service (CDMS).

The ISWG has considered the various risks and other associated issues that will likely need to be addressed in a comprehensive risk management strategy. Some of these include:

- Physical security of the data
- Utility of the data
- Sustainability of the SPGPPS's CDMS over time.
- Integrity and validity of the National Model
- Stakeholders' agreement that the ongoing implementation of the National Model is a joint venture

Development of new outcome measures of consumer and carer satisfaction, to address their perceptions of care, and their perceived needs.

The ISWG has referred this matter to the Australian Private Hospital's Association (APHA) Psychiatric Subcommittee for it to work with our National Network for Private Psychiatric Sector Consumers and Carers and our newly appointed SPGPPS Representative on the AHMAC National Mental Health Working Group Information Strategy Committee (ISC), Ms Moira Munro.

Improvement of the understanding of the CDMS and publication of its value, and research potential, widely through relevant journal articles, press releases, conference presentations and collaborative relationships with relevant academic organisations.

The ISWG has agreed that individual SPGPPS stakeholder organisations need to address this issue. Current funding does not permit Secretariat to undertake this work.

Accurate assessment of the issue of psychiatric admissions from non-psychiatric private hospitals.

Mr Morris-Yates will prepare material to present to the ISWG to enable them to develop a specification for exactly what questions need to be asked of the HCP data held by the Australian Government.

Dr Pring is Chair of the SPGPPS Information Strategy Working Group

Alternative Models of Funding

Mr Brian Osborne

The AHIA Mental Health Committee held a *Funding Models Workshop* in November 2003, at which a number of different approaches to the funding of mental health services by various health funds were presented. Health Funds see private psychiatric services, as a high cost area for its size and sometimes Health Funds decline to provide funding for programs for the following reasons.

- Health Funds are traditionally wary of new programs that represent an additional cost on top of an already high-cost area.
- It is very difficult to objectively assess the effectiveness of a program among the range of treatments and modes of treatment offered.
- A more sophisticated approach is to ensure, beforehand, that a new program is a true substitute for services and that it will facilitate a more appropriate service.

Some of the approaches discussed at the *Funding Models Workshop* and presented at the 36th SPGPPS Meeting are described below.

Program-based Payment Model

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

The Program-based Payment model aims to provide a total profile for Health Funds of funded psychiatric services. The advantages of this model are that it is a simplified alternative method of funding that is relatively low risk to all parties. It shifts the focus from revenue to standards of clinical practice and is an opportunity for further discussion and funding options.

The Prospective Payment Model

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

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

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

The Case Management Model

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

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

Mental health may also be considered as a common or chronic problem. A similar approach may therefore be of benefit for members with chronic mental health problems.

Undoubtedly, problems would be met such as access to 24-hour support, shared records and clinical acceptance, but these are being overcome in the medical area.

The suggestion is that Funds without current arrangements that already potentially capture this type of service, may be interested in talking with Hospitals, or other providers, about the provision of some form of appropriate and on-going clinical case management and support of members with 'chronic' mental health problems.

Mr Brian Osborne is a Health Fund representative on the SPGPPS

Towards Better Mental Health for the Veteran Community

Mr David Morton

The Repatriation Commission is proposing reforms to mental health care services for veterans. The proposed reforms will strengthen assessment, treatment and continuity of care and improve access to a broader range of mental health care for veterans. This will encourage providers to offer a better mix of hospital and community based mental health services and where clinically appropriate, use of community based alternatives to inpatient mental health services

Encouraging a better mix of care

These reforms will facilitate better use of community-based alternatives to inpatient treatment where this best fits the needs of the veteran. The Commission will work with providers on new arrangements that will create positive incentives to explore these sorts of alternatives. Together we will ensure that veterans are able to access services that deliver best practice for improving mental health for veterans.

Hospital based veteran mental health treatment can be divided into two areas:

- inpatient acute psychiatric care; and
- outpatient or day therapy programs.

At the moment, inpatient care constitutes the overwhelming proportion of mental health treatment provided to veterans. Of the remainder, outpatient programs are either PTSD programs that are contracted separately or a range of programs for other mental health conditions, which are paid for using a same day psychiatric care rate.

It is suggested that inpatient psychiatric care be divided into three categories. The categories are:

- Acute care, a short admission to stabilise patients undergoing a severe episode;
- Rehabilitation care, which incorporates inpatient admissions for programs ranging from Drug and Alcohol to social and living skills; and
- Psycho-geriatric care, a longer term and generally a lower acuity form of care.

This mix reflects the differing needs of mental health inpatients, the differing costs of their treatment and the different expected lengths of stay.

Strengthening existing community based options

Strengthening referral linkages and promoting shared care arrangements between specialist and primary health care providers who have existing arrangements with DVA will improve integration and continuity of care for veterans, their families and carers. A mix of providers means the Commission can encourage a more coordinated approach to mental health care that recognises the relationship between physical and mental health conditions.

It is important that veterans and their families are informed about their treatment choices and take charge of their own health and wellbeing. Therefore, in addition to improving access to treatment services, the Commission recognises the value of promoting individual self-help and social support activities as part of a community-based approach to mental health care.

Recovering mental health and wellbeing

Many mental health conditions are episodic and people will have reduced symptoms for periods of time. Evidence from evaluation of VVCS programs demonstrates that veterans and their families do improve their quality of life through more active participation in community, recreational or voluntary activities. Whether it is healthy lifestyle programs, through VVCS or formal psychosocial or even, vocational rehabilitation programs, each of these have a place in supporting veterans and their families in the process of recovery as they face the challenge of living with mental illness or mental health problems.

Invitation to Comment

Members of the veteran community, health providers and any other interested organisations were invited to provide comment on the proposed reforms by the 30 June 2004. For further information the contact officer for this paper is David Morton - Director Mental Health Policy Unit, (02) 6289 6601. Copies of this paper and the DVA Mental Health Policy and Strategic Directions statement are available from the DVA web site at:

www.dva.gov.au/health/younger/mhealth/policy/index.htm

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