

Collaboration
between
Public and
Private Sector
Psychiatry



**Human
Services**



Peoplefirst

**Collaboration between
Public and Private Sector Psychiatry
Victoria's Mental Health Services**

**Aged, Community and Mental Health Division
Department of Human Services**

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Foreword

A new context for the delivery of mental health services now exists in Victoria. Public mental health services are a more integrated part of a general health care system.

To ensure a coordinated response to the often complex needs of people with mental illness, public mental health services are increasingly required to develop and maintain partnerships with other services and sectors. Relationships with General Practitioners, Psychiatric Disability Support Services, child protection, youth and family support agencies and general health services have all been the focus of significant policy development and joint project activities over recent years.

The *Second National Mental Health Plan* recognises the importance of partnerships in service reform and delivery. The relationship between public mental health services and the private mental health sector is identified as a key strategic alliance.

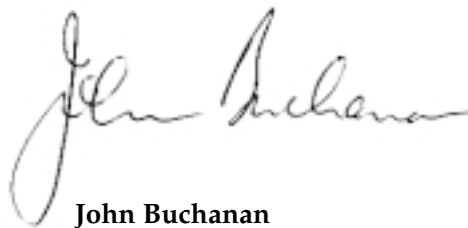
While there are clearly benefits to be obtained from closer collaboration between public mental health services and private psychiatrists, both sectors need to further develop their knowledge about how best to achieve collaboration. This document aims to build on the guidelines provided in *Collaborative Service Arrangements—Private Psychiatrists and Public Mental Health Services (1996)* and act as a practical guide for mental health service providers.

In recognition of one of the Victorian Government's four Key Pillars, "Growing the Whole State", case studies for the document have been drawn from across the state. We hope that they demonstrate that collaborative care arrangements can be established in both rural and metropolitan areas, as well as the improvements in service delivery that they can bring.

With its inclusion of a broad range of possible models, we feel confident that this document will prove to be a valuable resource for service providers keen to develop a more integrated approach to mental health service delivery.



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Contents

Acknowledgements	ii
Foreword	iii
1. Introduction	1
1.1 <i>Background</i>	1
1.2 <i>Towards Increased Collaboration</i>	1
1.3 <i>This Document</i>	2
2. Principles for Collaborative Arrangements	4
2.1 <i>Commitment of Clinicians</i>	4
2.2 <i>Ensuring Continuity of Care</i>	5
2.3 <i>Clear Communication Mechanisms</i>	6
2.4 <i>Appropriate Remuneration for Private Psychiatrists</i>	8
2.5 <i>Planning and Collocation</i>	10
2.6 <i>Senior Managerial Support</i>	11
2.7 <i>Obtaining Patient Consent and Assuring Confidentiality</i>	12
2.8 <i>Taking Context into Account</i>	13
3. Benefits of Collaboration	15
3.1 <i>Improved Access for Consumers</i>	15
3.2 <i>Access for Providers to a Wider Range of Knowledge and Advice</i>	16
3.3 <i>Increased Retention of Psychiatrists within the Public Mental Health Sector</i>	17
3.4 <i>Improved Care for Rural Patients</i>	18
3.5 <i>Opportunity for Private and Public Practitioners to Expand their Areas of Practice</i>	19
3.6 <i>Development of a Cohesive Local Approach to Mental Health Service Delivery</i>	19
4. Continuing Challenges	21
4.1 <i>Change Management</i>	21
4.2 <i>Legal and Contractual Issues</i>	21
4.3 <i>Demands on Organisational Resources</i>	23
4.4 <i>Differences and Limitations of the Sectors</i>	23
4.5 <i>Evaluation and Continuous Improvement</i>	24
5. Summary	27
References	29
Appendix	31

1. Introduction

1.1 Background

The *Second National Mental Health Plan* recognises that the relationship between public mental health services and the private mental health sector is one of the key partnerships in service reform and delivery.

Private psychiatrists have an important role in the provision of specialist mental health services. For many people experiencing mental health problems, they provide a service that is highly individualised, ensures continuity of care over very long periods of time and offers particular expertise in different areas of mental health care. Public mental health services offer a variety of multimodal and multidisciplinary interventions and treatment responses within a framework of case management.

Australia has almost 2000 specialist psychiatrists in the workforce (Commonwealth Department of Health and Aged Care, 1999). Over 90% practice in major urban centres, the majority in the private sector. To date there has been limited interaction between the public and private sectors in mental health in Australia. As a result, individuals have sought treatment from one sector or the other but have less frequently received services from both sectors concurrently. In the past, this has meant that some people with a mental illness, and their families or other carers, have been faced with a difficult choice about treatment options or service providers. For some this choice may involve striking a balance between the strengths and limitations of each sector. In the public sector, continuity of medical care can be limited, but patients receive the benefit of a service's multidisciplinary approach. In contrast, when a patient sees an individual practitioner they receive ongoing continuity of care within the psychiatrist's range of specialist expertise, but are often limited in the extent to which they can access after hours and outreach care.

At times, the historical barriers between the two service sectors have also resulted in difficulties for those working in private practice in accessing public services for their patients. Further, barriers between the two sectors have prevented the expertise to be found in each sector from being freely exchanged, to the potential detriment of service providers and their patients. Recent surveys of the psychiatric workforce have highlighted the difficulty that patients and service providers experience in accessing private psychiatrists, and the uneven distribution of private practitioners in rural and metropolitan areas.

1.2 Towards Increased Collaboration

Increasingly, in recent years there has been development of liaison and joint service delivery arrangements between public mental health services and private psychiatrists. These arrangements have varied greatly in both scope and purpose. The document *Collaborative Service Arrangements—Private Psychiatrists and Public Mental Health Services (1996)* was developed by the Mental Health Branch and recognised that a formalised and consistent approach to collaborative work would be beneficial. It provided a guide to the development of cooperative partnerships between the two sectors.

The Department of Human Services, Mental Health Branch and the Royal Australian and New Zealand College of Psychiatrists (Victorian Branch) established a Joint Working Party to improve collaboration between the two sectors based on best practice and the principles outlined in the 1996 Collaborative Service Arrangements policy document. Key tasks have been identifying practical principles for collaborative service arrangements, and promoting the development of new and innovative models.

The Commonwealth Government has also made funding available for National Demonstration Projects in Integrated Mental Health Care. The aim of these projects is to trial ways of integrating private psychiatric services with public sector mental health services. The purpose is to create a more flexible integrated framework within which mental health care can be delivered. The model for the trials is premised on collaboration between private psychiatrists and the public mental health system to provide an integrated service for the population of a defined area.

1.3 This Document

This document presents principles to enable mental health services to commence and/or continue work aimed at increasing collaboration between public mental health services and private psychiatric services. To this end, many of the potential benefits of such collaboration are discussed along with some of the challenges presented by such approaches. The document recognises that the success of collaborative care depends in some part on choosing the right model for the right circumstances.

Broadly speaking, collaborative models can be divided into service provision and non-service models. The following is a non-exhaustive list of possible collaborative models in the two categories:

Service provision models

Collaborative Care Procedure: The public and private service providers establish an agreed procedure for cases where collaborative care would benefit a patient, but they remain geographically separate. Roles and responsibilities are identified and continuity of care is facilitated through clear communication mechanisms.

Collocated Suites: Private consulting suites are established within or adjacent to the public mental health service. Psychiatrists working at the mental health service may set up a limited private practice at the suites, allowing them to maintain continuity of care with patients who have left the care of the public service.

Telepsychiatry (Primary consultations): A public or private psychiatrist in one geographical area sees and assesses a referred patient in another geographical area via videoconferencing technology. The referring clinician is also visibly involved in the videoconference, and the psychiatrist consults with the referrer after assessing the patient.

Linkage unit: Rather than providing direct services, the unit operates as a broker between the two sectors. Public services seeking a private psychiatrist for a particular patient access the unit for information on areas of expertise and availability. Similarly, private psychiatrists seeking public services are able to access them through the linkage unit.

Individual initiatives: In collaboration with local services, individual private practitioners provide mental health consultations to rural or regional areas that have a shortage of psychiatrists.

Non-service provision models

Education/Discussion Groups: Public and private psychiatrists from a local area meet regularly to provide mutual support, provide a forum for visiting speakers and explore opportunities to provide a more cohesive mental health service to the local area.

Telepsychiatry (Secondary consultations): Public and private psychiatrists in different geographical areas discuss a patient's clinical issues via videoconferencing technology. The patient is not present at the consultation.

Individual initiatives: Individual private or public psychiatrists provide support or training to psychiatrists outside their own sector. This model is particularly useful when used with registrars and rural psychiatrists.

Case studies of these models are used to illustrate points throughout the document. Information for the case studies has been gained from two main sources. Firstly, an analysis has been made of relevant documentation, including project reports, service procedures and written agreements. Secondly, members of the joint working party have undertaken discussions and structured interviews with key participants in the arrangements.

2. Principles for Collaborative Arrangements

2.1 Commitment of Clinicians

One of the most important principles driving the achievement of successful collaborative outcomes is the commitment of mental health professionals, either as individuals or members of a clinical team. An active cooperative relationship between the public and private service providers is integral to the achievement of successful outcomes. In the first instance, there must be recognition that patients could benefit from access to the other service provision sector. At this early stage, it is also beneficial for practitioners to acknowledge that they will potentially benefit from a collaborative care arrangement. In some cases, there has been friction between the public sector and private providers. If a collaborative arrangement is to be successful, previous differences of opinion or approaches may need to be put aside. While there are undeniably benefits for clinicians involved in collaborative care, a commitment to appropriate compromise may also be required if improved patient care outcomes are to be achieved.

South West Healthcare (Warrnambool)

South West Healthcare covers a large rural area in South-West Victoria, including Warrnambool. The area currently has access to three private psychiatrists.

Collaborative arrangements at the South West Healthcare Psychiatric Services Division originally developed out of a need to address significant tensions between the public and private sectors in the area. Discussions to resolve these issues allowed those involved to reach agreement to advance their shared commitment to improving service provision in the area.

Resolution of the tensions would not have occurred without the willingness of all stakeholders to develop a shared vision. The private psychiatrist involved was willing to work alongside the public mental health service in its redevelopment and the service Manager and Director of Clinical Services were prepared to consult extensively with the private practitioner with regard to service planning and development activities.

Some three years after the original guidelines were agreed upon, public and private providers involved agree that the system works very well. In part this can be attributed to the rural location of the service. Rural settings can be viewed as closed service systems in that there exist a relatively small number of service agencies. Distances are often too great for people to attend specialist out of area services. A sense of mutual responsibility develops in such systems, along with the knowledge that any potential tensions must be resolved quickly. The more flexible approach made possible by practice in a rural area also allow administrative compromises to be made on occasion in the interests of maintaining good relationships between service providers.

It is sometimes argued that it is beneficial in a service provision model if the psychiatrists working with the public mental health service have experience of or ongoing involvement with public sector psychiatry. Pre-existing relationships can enhance the capacity of the two sectors to collaborate, but a committed private practitioner with no previous links can make just as large an impact.

AN INNOVATIVE APPROACH

Private psychiatrist John Nathar is an example of how the commitment of one individual can have a considerable impact on the care choices available to patients in rural areas. Over a period of 16 years, Dr Nathar piloted his plane to Swan Hill every three weeks, to conduct a private practice and undertake consultation work.

The private room and administrative support were initially provided by the local hospital and then later, the mental health service. This transition to working with the mental health service allowed an even closer liaison to develop with the public psychiatric team. While referrals were predominantly received from local general practitioners, the care of patients would then be shared between Dr Nathar and the public mental health service.

When Dr Nathar was running his main practice in the metropolitan area, regular phone contact was maintained with the public mental service to discuss the progress of patients or their medication needs. The arrangement allowed patients to see a private psychiatrist on a semi-regular basis, while still being able to call upon the mental health service for additional support if necessary.

From the point of view of Dr Nathar, the arrangement created an additional support network for his patients. During his infrequent visits he did not have the time to provide ancillary services such as stress management. However, he knew that he could rely on trained staff of the public mental service to provide these additional services at other times. The arrangement also made easier the task of distance management, as he knew that there was someone 'on the spot' who could see patients urgently when required.

2.2 Ensuring Continuity of Care

Closer links between private psychiatrists and public mental health services enable greater continuity of care for mental health consumers. In instances where a private patient is admitted to a public inpatient facility, greater involvement by the private psychiatrist in their care is possible when there are pre-existing links between the private psychiatrist and the public service. Continuing case management by a public sector service does not preclude care and treatment being provided within the private sector.

The Carrington Consulting Suites at The Koonung Community Mental Health Centre (KCMHC)

KCMHC is one of the two community based continuing care, clinical and consultancy services within the Central East Area Mental Health Service.

Developing links with private providers in the local area had been an ongoing challenge for the KCMHC. The service saw a need to work with a pool of private providers who would be willing and able to receive referrals in instances where a private psychiatrist was believed to offer the most appropriate treatment response to an individual client. When the KCMHC moved to new premises and it became clear that it would be difficult to find tenants willing to share with a Community Mental Health Centre, the idea of establishing private consulting suites was raised. As a result, the Carrington Consulting suites were established by the public mental health service.

Referrals to consultant psychiatrists working out of the Carrington Suites come from both general practitioners in the local area and from the Central East Area Mental Health Service. Often referrals from the public mental health service are managed initially on a shared care basis before generally undergoing a transition to fully private care.

The model of collaboration introduced at the Koonung CMHC enhances continuity of care for consumers who have received a public inpatient service and who, on recovery from the acute phase of their illness, require ongoing private psychiatric treatment. In many cases such consumers are able to continue to be seen, on a private basis, by the same psychiatrist responsible for their care while in the inpatient unit.

Clinicians and service providers will need to consider the most effective strategy to employ in their model to enhance patient continuity of care. Ware et al (1999) suggest a number of strategies that can be employed to create continuity for patients when they move across service sectors. Clinicians should be aware of ensuring smooth transitions, including having regard to other areas of the patient's life. When a patient is about to undergo a major change in their care regime, attempts should be made to keep other elements of their life as stable as possible. For example, a change in housing and service provider in the same week should be avoided. If possible, it can be beneficial to make change gradual and to slowly increase contact with the new provider. New providers should also make themselves familiar with client's records before meeting them, thereby minimising the need for them to repeat potentially painful life histories. It can also be beneficial for clinicians to offer an historical perspective on a patient's care history to the new clinician. This will ensure that the new clinician understands the context of a patient's current behaviour.

These strategies are well within the reach of clinicians and are compatible with day-to-day service provision. However, it is also important for the appropriate structures to be in place at program level to facilitate the exchange of information in a timely and systematic way. Continuity of care is not only the responsibility of the individual clinicians involved with a patient, but also the service provider as a whole. This need for clear communication structures is explored in the next principle.

2.3 Clear Communication Mechanisms

Clear communication between the public and private sectors must be at the heart of any effective collaborative arrangement. In the case of service provision models, clearly defined roles and responsibilities are the best strategy to ensure that all concerned receive the maximum benefit from the arrangement. Even after roles and responsibilities are established, regular communication should continue between the public provider and private psychiatrist. Communication may be informal and take the form of regular telephone contact between the private psychiatrist and key staff from the public mental health service. In other cases, a more formal arrangement may be appropriate. For example, psychiatrists involved in a collaborative care agreement about a patient could submit a three-monthly written report on the status of the agreement, and provide a summary of the treatment to the patient. The report could include a recommendation about whether the arrangement should continue or whether a full referral should be made to one sector. The public sector clinicians should also communicate their views regarding the need or purpose of continuing involvement.

As the collaborative arrangement develops or new clinicians become involved, it will be necessary to review the procedure. It is only through the practical application of the procedure in a number of different cases that gaps or ambiguities become apparent.

South West Healthcare (Warrnambool)

In 1997, a collaborative service policy was developed between the South West Healthcare Psychiatric Services Division and the sole private practitioner in the local area at the time. The procedure was updated in March 2000 in consultation with the three private psychiatrists now practicing in the area. There was felt to be a need for private psychiatrists to indicate the type of care they think their patient could benefit from that they are unable to provide, as well as the approximate period of time for which the care will be required. The revised procedure allows the public service to continue to maintain a degree of control over its caseload. This ensures that collaborative care patients do not impinge upon the care being provided for current clients by the public sector.

The following are some of the key stages set out in the procedure:

- Initially, requests may be made in person, by letter or by telephone for the provision of collaborative care for existing clients by private psychiatrists.
- If they have not already done so, consultant psychiatrist (from the public mental health service) should ask the private psychiatrist to put the request in writing.
- The consultant psychiatrist and clinical therapist should ensure that the multi-disciplinary team is informed of all requests for collaborative care.
- The decision to accept a referral for collaborative service delivery is to be made by the relevant treating team and authorised psychiatrist.
- The client and their family/carers as appropriate must be included in discussions to develop a collaborative care arrangement. Collaborative care cannot proceed without the approval of the client even if a private psychiatrist makes such a request.
- The purpose of the collaborative care agreement must be clearly identified and agreed upon between both parties providing services to the client. The private psychiatrist and clinical therapist, and if relevant the key worker, must be involved in developing the agreed plan.
- General agreement must be reached around the form, nature and extent of communication and information sharing.
- Whilst the component of service provision being requested by a private psychiatrist will fall within the domain of the appointed clinical therapist or a designated key worker, there shall be an expectation that the private psychiatrist will be actively involved in the ongoing management of the client in collaboration with the clinical staff of the division.
- The progress of treatment and compliance with treatment by the client shall be reported upon to the private psychiatrist at the agreed intervals.
- The Director of Clinical Services must be informed of all situations where there is disagreement/conflict in relation to the development or implementation of collaborative care service provision.

It is also crucial for communication mechanisms to be in place between the patient and their clinicians. Although the consent of the patient is required before any collaborative arrangement can commence, this does not preclude the possibility of a grievance arising at a later stage with a new clinician. A clear procedure should exist for complaints and dispute resolution. Dispute resolution mechanisms may be required for patients who are no longer happy with the collaborative arrangement, those who feel that their privacy has not been adequately protected during the arrangement, or those who want to dispute the billing procedure. Communication should always be a two way process.

St. Vincent's Mental Health Service—Public and Private Partnerships in Mental Health (Partnership Project)

In January 1999, St. Vincent's Mental Health Service (SVMHS), The Melbourne Clinic (TMC) and St John of God Healthcare (SJOGHC) successfully tendered for funding from the Commonwealth Department of Health and Aged Care under the National Demonstration Projects in Integrated Mental Health Care. The Project is being implemented over the period of November 1999 to April 2002.

The Partnership Project aims to improve the effectiveness of mental health services in the Inner Urban East area of Melbourne by fostering cooperation and collaboration between public and private mental health service providers.

There are two major strategies to achieve the Project's goals. The first is the development of a Public and Private Linkage Unit to provide a mediating system between public and private services. The Linkage Unit will facilitate communication, support shared care arrangements, develop linkages with primary care and non-government organizations, educate both public and private providers and promote shared understandings. The second strategy is the development of additional funded activities for private psychiatrists to include non-direct care activities such as secondary consultation, supervision, and case-planning.

All patients who participate in the Project will have access to the SVMHS complaints process. This policy provides a detailed description of SVMHS responsibilities in relation to the investigation, resolution and monitoring of complaints. The St. Vincent's Hospital Patient Representative is one avenue of complaint and the St. Vincent's Hospital Patient Care Review Committee review the number and nature of complaints. This procedure ensures a high level of accountability and transparency in the management of complaints. In addition, all consumers involved in the Project will receive written information about complaint processes.

2.4 Appropriate Remuneration for Private Psychiatrists

A system for the payment of private psychiatrists involved in a collaborative arrangement is an important consideration in service provision models. In cases where a collocation arrangement has not been established, it can be costly for a private psychiatrist to be away from their practice for extended periods of time. In financial terms, they are still required to pay their rent and administrative staff. Professionally, the more time they spend working with the public mental health service, the less time they have available to see their private patients. When making a decision about the payment method to be used for private psychiatrists, it is also important consider the effect the decision will have on patients. Patients who are normally seen in the public sector may have reservations about moving to a fee-paying service. Public sector clinicians need to be able to openly discuss with patients the costs involved if referral to a private practitioner is contemplated.

The Carrington Consulting Suites at The Koonung Community Mental Health Centre

Many of the consultant psychiatrists in the Carrington Suites bulkbill, but others will bill according to patients' capacity to pay. Consultant Psychiatrists pay for use of the suites on a sessional basis in order that the Suites are financially self-sufficient and public funds are not diverted to the private setting. In exchange, psychiatrists are supported by a Practice Manager and reception staff that provide telephone, secretarial and billing services.

Limited changes to remuneration for private psychiatrists are currently being mooted. The Funding and Financing Options Working Group, a subcommittee of the Australia and New Zealand Telehealth Committee (ANZTC) has developed a submission for the introduction of an MBS item to provide rebates for the provision of primary consultation by private psychiatrists via videoconferencing. This development could assist in the cultivation of further public-private relationships, as private psychiatrists would be remunerated for carrying out consultations with a public psychiatrist and their patient via videoconference.

Private psychiatrists involved in collaborative care can use Medicare to be remunerated for the face-to-face (primary) consultations they undertake with patients. Until recently, however, there has not been an MBS Item for secondary consultation, meaning that private psychiatrists remain out of pocket for any additional work they carry out for the patient, such as consulting with other clinicians about their case or discussing options with the patient's family or carers. Progress has been made in this area, with new case conferencing Medicare item numbers (801–815) introduced from 1 November 2000. Private psychiatrists can now be remunerated for case conferences where there are three other care providers from different disciplines, possibly including a general practitioner. Case conferences are limited to five in a twelve-month period.

St. Vincent's Mental Health Service—Public and Private Partnerships in Mental Health (Partnership Project)

Extensive discussions and consultations have occurred regarding the funding arrangements for the participating private psychiatrists. The consultations were informed by the guidelines provided by the Commonwealth Department of Health and Aged Care in Section Three of the *Planning Guidelines for National Demonstration Projects in Integrated Mental Health Care*. A number of principles were developed to assist in identifying the most appropriate mechanism for paying private psychiatrists. It was agreed that funding arrangements for participating private psychiatrists should:

- Promote the best treatment for patients and maintain clinical and ethical standards of practice.
- Improve access and case coordination for patients with complex needs.
- Promote access for disadvantaged communities to both public and private services.

The project proposes to facilitate greater participation by private psychiatrists in public sector mental health care. Direct patient activities will continue to be funded through the Commonwealth Medical Benefits Scheme (MBS). Funding for additional activities such as secondary consultation and supervision will be provided through the creation of additional item numbers. Within this arrangement, participating psychiatrists will bill the Health Insurance Commission for all direct patient activities under existing MBS arrangements. Psychiatrists will bill the partnership project for the additional activities developed by the project. While this option will require that participating psychiatrists have a dual billing system, it would require only a minimal change to the current funding arrangements.

These arrangements allow separation to be maintained between State and Commonwealth funding and for fee-for-service arrangements to continue. However, they also allow an evaluation of the changed funding responsibilities between the State and Commonwealth governments. Consistent with the aims of the Project, the funding arrangements provide a vehicle for a broader range of activities than is currently available in either the public or private system.

2.5 Planning and Collocation

Many collaborative arrangements initiated in the public sector aim to build external pathways to allow better access to care for patients. Arguably, these changes cannot occur until the internal system for the care of patients is clear. It can be difficult to encourage private providers to collaborate with the public system and vice versa if the pathways of patient care are unclear or complicated.

St. Vincent's Mental Health Service—Public and Private Partnerships in Mental Health (Partnership Project)

Before St Vincent's became involved in the Partnership Project, considerable work was undertaken to strengthen internal pathways of care and develop a simpler system. The service is now structured around an integrated team model. Crisis Assessment Teams and Mobile Support Teams are part of the larger team and patients are allocated to the team based on where they live. The same team (and usually case manager) manages the patient throughout their period of care. The clinical team as a whole will make decisions about inpatient admittances, not just one element of the team.

Due to the large and complex nature of the programs run by the service, it is perhaps not possible to run a fully integrated system, such as those often seen in rural areas. However, the structural changes made have clearly helped to facilitate collaboration with the private sector.

Collaboration can be enhanced by the collocation of the private consulting rooms with the public mental health service. Not only does this physical proximity facilitate communication, offer support and ensure an easier transition for consumers, but it also makes a very visible commitment to ongoing collaboration. A quid pro quo arrangement can be reached whereby subsidised room rental can be offered to private psychiatrists who agree to play a role in education, supervision or research for the public mental health service.

There are some potential disadvantages associated with collocation that can be identified. A private psychiatrist who is no longer geographically separate from the public service may feel less independent. Some of their patients might also prefer the two services to remain separate. Also, private psychiatrists need to be committed to working co-operatively with the procedures followed in the public organization, and the management of the public mental health service must be confident private psychiatrists will support these processes when the sectors are working collaboratively.

The Carrington Consulting Suites at The Koonung Community Mental Health Centre

Although the Carrington Suites are managed and operated completely separately to the public service, close ties have been fostered and maintained. This includes the development of a linkage agreement between the public service and the private suites, outlining how each section will work together and share the available space. Thorough consideration of the design of the private consulting rooms has been vital in ensuring their success.

The availability of skilled practice management and flexible working arrangements for private practitioners, along with an explicit commitment to ensuring that the range of specialties and skills offered in the private rooms is complementary to the public mental health service, have also been integral in ensuring that the benefits are evident to all stakeholders.

A clear procedure exists for the recruitment of private psychiatrists. Psychiatrists are approached to work in the Suites and a committee comprising the Director of Clinical Services, the Manager from the Central East Area Mental Health Service and the Practice Manager review applicants to ensure they have a commitment to working in a collocated service, and will enhance the skills and specialties already represented.

Less formal collaboration models also require considerable planning. Developments may require an initial identification of the difficulties that have arisen between the two sectors and the development of a means of addressing these. The arrangement developed should be the end point of this undertaking. It is unlikely to be effective if the necessary preparatory work has not been carried out.

2.6 Senior Managerial Support

It is particularly important within the public sector to ensure that any model of collaboration is championed throughout the service. Ensuring that all staff have a complete understanding of the role of the sectors and the systemic relationship between them is critical to the success of any collaborative model. Similarly, it is important that such arrangements are vigorously supported by the RANZCP and its associated committees.

South West Healthcare (Warrnambool)

The commitment of the Director of Clinical Services and the Area Mental Health Service Manager to establishing protocols for service provision with private psychiatrists was vital to these protocols being universally adopted throughout the service. Management of the public mental health service made a firm commitment to the redevelopment of the service system and to a comprehensive program of staff training. This has increased the confidence of one of the private practitioners, in particular, that all staff have a specified level of skill and knowledge.

St. Vincent's Mental Health Service—Public and Private Partnerships in Mental Health (Partnership Project)

After two years of planning, the Partnership Project was recently the first of the National Demonstration Projects to go “live”. Along with a considerable amount of effort and work, the support of management has been key to the Project's success thus far. Management have not only assisted in developing the Project, but they have also been instrumental in ensuring that the Project's value is understood throughout the service. The recent experience of management in facilitating the transition from a stand alone mental health service to one mainstreamed with a general hospital has assisted the change management process.

Collocation of private and public rooms is not sufficient to ensure that the two service sectors operate in a collaborative manner. Only the involvement of senior management and private practitioners in the planning, establishment and ongoing negotiation of these arrangements can ensure that all staff are aware of the importance of liaison and cooperation with the private sector. Depending on the nature of the collaborative model, support of relevant auspice bodies can also be a prerequisite.

The Carrington Consulting Suites at The Koonung Community Mental Health Centre

The establishment of the Suites was very much dependent on the support of the auspice hospital – Preston and Northcote Community Hospital. The auspice hospital was prepared to invest in the initiative and provide advice about the challenges of balancing private and public service provision, assessing whether the business unit had the potential to be viable, developing a business case and formalising contractual arrangements. These challenges, while familiar in the acute health sector, were new to the recently mainstreamed psychiatric service.

2.7 Obtaining Patient Consent and Assuring Confidentiality

One of the key principles for patient care identified in 1996 Collaborative Service Arrangements document was that ‘consent to disclosure of information between the service providers in the public and private sectors must be given by the patient before the Collaborative Service Arrangement can be put in place.’ Ideally, this principle will be included in the written material for an arrangement.

South West Healthcare (Warrnambool)

Psychiatric Services Division
Policy & Procedures Manual

Procedure: Collaborative Care

(Extract from page 3)

Action: Discuss with client and family/carers and obtain consent for exchange of information.

Responsibility: Clinical Therapist

Guidance: The client and their family/carers as appropriate must be included in discussions to develop a collaborative care arrangement. Collaborative care cannot proceed without the approval of the client even if a private psychiatrist makes such a request.

The client’s written consent must be obtained for the disclosure of information between the Division and the private psychiatrist.

Whenever a change is made to the nature of the collaborative arrangement, patients need to be reassured that the confidentiality of their records will be stringently maintained and that they can withdraw their consent for the collaborative care arrangement if they so choose. In order for patients to give informed consent, they also need to be made fully aware of clinicians’ plans for sharing information. It may be advisable to reconfirm a patient’s consent to the information sharing arrangement if particularly sensitive material is to be shared for the first time.

St.Vincent’s Mental Health Service—Public and Private Partnerships in Mental Health (Partnership Project)

Consultation with consumers has been a core element of Project development. A Consumer Consultant from St Vincent’s Mental Health Service (MHS) was nominated to join the Project committee to provide a consumer perspective. In addition, a consumer with substantial experience of the private psychiatric sector was nominated to join the committee through the Victorian Mental Illness Awareness Council, a peak Victorian mental health consumer body. Consumer feedback has generally been positive about plans to further extend collaborative care arrangements. However, one area of concern expressed has been about confidentiality, privacy and informed consent.

2.8 Taking Context into Account

The effectiveness and appropriateness of any form of collaboration will be greatly influenced by the service provision context. For rural services, the limited number of private providers is both a problem and a means to establishing strong collaboration. While the absence of a pool of private providers inevitably raises demand issues, it also allows very close and comprehensive collaboration between the two sectors to occur. The closer relationships made possible by a rural location may also facilitate the creation of a model which includes more service providers than would be possible in a metropolitan setting. The close collaboration and shared vision for the provision of mental health care that occurs in a rural area may be more difficult to establish in a metropolitan area with a high number of private psychiatrists.

Ballarat Public and Private Psychiatrists Group (BPPPG)

The Grampians region comprises a population of over 200,000 people with an area of 48,000 square kilometres in rural Victoria. The area now has more private psychiatrists than public, due to the recent movement of four public psychiatrists into the area’s private sector. The advantage of this shift is that there is greater access to private psychiatrists than ever before.

For the past four years, all psychiatrists, both public and private, from the area have been meeting as the Ballarat Public and Private Psychiatrists Group (BPPPG). The BPPPG arose out of the interest of all the local clinicians, who saw value in meeting regularly as colleagues providing a service to patients in a region. At the time, there were recognised tensions developing between the two sectors, but these were resolved in the Group’s early stages. Now, the members consider themselves to be consultant psychiatrists providing a service to the community, with the guiding principle being that patients should be able to enter the system from either sector. The group meets every two months in the evenings and aims to:

- Unify and provide a comprehensive psychiatric service for the people in the Ballarat area and its environs.
- Develop and liaise with general practitioners.
- Provide mutual support.
- Undertake peer review, journal presentations and provide a forum for visiting speakers which meet requirements for the RANZCP MOPS (Maintenance of Professional Standards) program.
- Provide an opportunity for collaborative research.

- Facilitate follow up for drug trials (e.g. where a participating patient transfers between the sectors).
- Explore opportunities to develop a consultation/liaison network with individual clinicians having specific interest areas, and; establish links and further support with the Rural Psychiatrists Association of Victoria.

Through shared information, support, research and education, individual psychiatrists are more readily able to respond to client needs and identify a colleague who may have specialist skills in relation to particular needs.

It is the view of the BPPPG's Secretary that the Group has consistently met its aims over a prolonged period because all of the members are committed to being involved. The Group remains quite informal, eliminating the need for bureaucracy. It is testament to the Group's strength that it has continued to meet despite the recent upheaval in the area. For the group the essential change is that some members who have always worked in the public sector are now private practitioners.

South West Healthcare (Warrnambool)

It is the belief of a clinician within the public mental health service that the collaborative care arrangement has been successful because it is part of a community-wide collaborative approach. Emphasis is placed on the patient's functional impairment, rather than their diagnosis, with an effort being made to return patients to their general practitioner and family or carers within one to two years. GPs are equipped with the knowledge to maintain the patient's care regime, prescribe appropriate medication and detect early warning signs. It is unusual for such an approach to be applied in the metropolitan area, where the lines of communication between the various providers of mental health services, patients and their carers, GPs and the other community services can be unclear.

3. Benefits of Collaboration

3.1 Improved Access for Consumers

Collaborative Care

Collaborative care arrangements can offer consumers access to the advantages of both systems. The public mental health service offers comprehensive case management that is not usually available through a private psychiatrist. In addition, the patient has the opportunity to receive more intensive treatment by spending time with a psychiatrist who works in private practice. Such arrangements can also relieve some of the burden on medical staff within the public service, thereby improving access to the public mental health service for others who may need it. Such arrangements also rely on the capacity of private practitioners to organise their sessions such that appointment times are available for new referrals.

There are additional benefits for the patient when the two clinicians involved in the provision of collaborative care have an established professional relationship. In such cases, there is likely to be a clearer understanding of the contribution that each sector can make to the overall care of the patient, allowing the collaborative care process to operate more smoothly. In some cases, collaboration between the two sectors may already occur before formal protocols are developed. The formalisation of procedures between private and public practitioners assists in the development of mutually understood and accepted liaison practices, thereby improving the quality of collaborative care. The existence of a clear procedure may also encourage other parties to contribute to collaborative care arrangements.

The Carrington Consulting Suites at The Koonung Community Mental Health Centre

The experience of practitioners working out of the Carrington Suites has been that collaborative care arrangements can be enhanced further by the close proximity of the public mental health clinic to the private rooms. Face to face contact between all parties involved means delays in consultation are minimised and agreement can be reached quickly and efficiently. Such informal negotiations have been found by many of the practitioners to be less effective if conducted by phone or in writing and in particular if the communication is taking place between professionals who have not already developed a working relationship and a shared understanding of and respect for each others' roles.

For the consumer, the close proximity of the Carrington private consulting rooms and the public mental health service at Koonung CMHC is more convenient, as it is not necessary to attend separate locations in order to meet with the various professionals involved in their care.

Referrals

For consumers of mental health services, the transition from one service sector to another can be disjointed and stressful. Transition between sectors is optimal where there are close ties between the private practitioner and the public mental health service.

Public mental health services indicate that referrals from private practitioners benefit from the introduction of more collaborative arrangements. One result of collaborative activities is a greater understanding of the strengths and limitations of the public and private mental health service and more realistic service delivery expectations on the part of both sectors. This understanding enables private psychiatrists to more effectively facilitate a referral.

In the past, private psychiatrists have expressed concern regarding the difficulties they face in accessing the care of public mental health services for their patients when this is necessary. This can arise, for example, when inpatient treatment is required and the individual has no private health insurance and lacks the resources to pay for private inpatient care. Private practitioners, particularly in metropolitan areas, may raise concerns that the public mental health system questions the appropriateness of such referrals, or that the processes that need to be followed are unwieldy. Once they are involved in a model of collaboration, private practitioners report a greater understanding of and respect for the difficulties faced by public mental health services.

The Carrington Consulting Suites at The Koonung Community Mental Health Centre

Private psychiatrists find referrals of patients being discharged from the public system are clearer where services have a history of working together and direct contact. Consultant psychiatrists working out of the Suites indicate that, generally, staff of the public mental health service have a clearer understanding of private sector service delivery resulting in more appropriate referral. Public mental health service staff also suggest that they more readily make effective referrals to private psychiatrists when there is a pre-existing relationship with the practitioner.

In certain cases, collaborative care may not be the most suitable option for the patient. In rural areas, the public mental health service may be some distance away from where the patient sees their private provider. If the care of the patient is becoming disjointed, it may be beneficial for the private practitioner to facilitate a full referral to the public sector or for the public sector to discharge the patient to private care. Collaborative care can then recommence at a more appropriate time.

3.2 Access for Providers to a Wider Range of Knowledge and Advice

For public sector mental health professionals, access to psychiatrists with specialist knowledge is important to ensure the best possible response to an individual's needs. When a specific issue arises, such as working with clients with dual disabilities, staff have easy access to high quality advice from an expert in the field.

The Collaborating Centre—St Vincent's Mental Health Service (SVMHS) and St John of God Healthcare (SJOGHC)

Prior to their involvement in the Partnership Project, SVMHS and SJOGHC established the Collaborating Centre, private consulting suites located on the St Vincent's Hospital site. The development of the Collaborating Centre arose from concerns within the St Vincent's Hospital psychiatric service that new service arrangements would lead to reduced access to service for a traditional client group of the hospital. Many of these clients had previously received outpatient services following referral from the general hospital Consultation–Liaison program.

Private psychiatrists were invited to move their practices to the new centre and a consultation and assessment clinic established. The centre was established with a focus on bulk billing to provide an accessible service and a timely response. To facilitate this St Vincent's Hospital offers subsidised rental of the rooms.

Referrals to the service are sourced from local general practitioners, the general hospital Consultation–Liaison Service and the public mental health service. Psychiatrists pay for access to the Collaborating Centre on a sessional basis. This includes rooms, telephone services, secretarial resources, billing and practice management. The subsidised rental ensures that sessional fees are kept at a minimum.

Participating psychiatrists have been selected for their particular skills and specialist areas of practice that are considered complementary to service development needs and to the services provided by the public mental health service. In particular psychiatrists with an interest in providing services to survivors of child sexual abuse have established a specialist practice within the Centre. The existence of this specialist practice and expertise in the area of Consultation–Liaison (C–L) psychiatry provides a valuable resource for staff of the public mental health service.

Access to senior private and public sector psychiatrists is also useful for junior public sector medical staff. Collaborative arrangements can allow junior medical staff to forge professional relationships with those working in both public and private sector practice.

Private psychiatrists may experience a degree of isolation in their practice. While they may have access to specialist advice from other psychiatrists, they are less likely to be well connected with wider services that could be of benefit to their patients. Involvement in a collaborative care arrangement can broaden the range of health and community care professionals to whom the practitioner has access. Once private practitioners have built relationships with other health and community care professionals, they will be more likely to utilise their knowledge in gaining advice about the best course of action to follow with a patient.

3.3 Increased Retention of Psychiatrists within the Public Mental Health Sector

A high turnover of psychiatrists can become problematic for public sector mental health services. It is costly to constantly train new psychiatrists in the specific policies and procedures of the service. More importantly, retention of psychiatrists in the public sector is integral to the successful maintenance of patient continuity of medical care. Retention rates can be positively influenced by providing psychiatrists with the opportunity to pursue other areas of specialist interest through the establishment of a limited private practice.

The Carrington Consulting Suites and the Collaborating Centre

Frequently, the psychiatrists operating private practices at the Carrington Suites and the Collaborating Centre have retained positions within the public mental health sector. In many cases they hold full time positions within the public mental health service and undertake one or two private sessions each week. The opportunity to establish this limited private practice is greatly enhanced by the collaborative arrangements and provides an introduction to private practice within a managed practice environment.

The rooms are operated by a practice manager and secretarial, reception and billing services provided. Psychiatrists working full or near full-time in the public sector believe they would not have the capacity to maintain this workload and establish a private practice without the availability of these administrative supports.

Private psychiatrists with close ties to the public mental health sector also find that the relationship can offer an additional source of referrals of patients with a wide range of problems. This is particularly pertinent in newly established practices.

3.4 Improved Care for Rural Patients

The number of private sector psychiatrists in metropolitan Melbourne far exceeds those in rural areas, resulting in demand pressures and access issues in rural public mental health services. Liaison with public mental health services mitigates against the isolation experienced by rural psychiatrists in individual or small private practices. The existence of collaborative arrangements may help to retain private practitioners in rural areas, or even attract them to practice there initially.

Ballarat Public and Private Psychiatrists Group (BPPPG)

The psychiatrists who have recently moved across to the private sector have chosen to continue practicing in Ballarat. Arguably, the effectiveness of the BPPPG has been a contributing factor in their decision to stay in the area. The Group can be recognised as an important attraction for both public and private psychiatrists to the area. Practitioners who are interested in working in the area can be assured that all the local psychiatrists are committed to peer support and providing a comprehensive and integrated service system for patients. The group also provides an innovative venue for the discussion of clinical problems and opportunities for joint research and professional development.

Collaborative care for the benefit of rural patients can also occur through more innovative methods. Increasingly, pilot projects in telepsychiatry are providing the opportunity for public and private psychiatrists in rural areas to consult and liaise with their metropolitan counterparts. Consultation via videoconferencing technology allows for a balance to be struck between competing considerations. Rural practitioners benefit from the knowledge of colleagues, without these colleagues being required to move their practice (and personal life) away from the metropolitan area.

The Monash Telepsychiatry Project (Southern Health Care Network)

The Monash Telepsychiatry Project linked private psychiatrists videoconferencing from their Melbourne offices with the child and adolescent mental health services for East Gippsland, Northern and Southern Tasmania. The project was evaluated and videoconferencing proved suitable for the provision of psychiatric consultations to regional clinicians. It was found that the effectiveness of the consultations relies more upon the people involved than the technology and begins with a common understanding about the task. It is important however, that the technology be reliable, transparent and able to convey the subtle non-verbal communications fundamental to everyday interactions.

The project found that videoconferencing can successfully be used for direct patient assessment and consultation about treatment, consultations between clinician and consultant and educational sessions using a variety of formats. Videoconferencing is well suited to the provision of secondary consultation, in which the patient is not present, especially those involving more than one clinician.

Secondary consultations provide benefits to all practitioners involved, including:

- Alleviating professional isolation.
- Assisting ongoing professional education.
and;
- Developing technical skills.

Teleconsultation was found to be cost effective, even at low volumes of 6–7 hours per week, when compared with the cost of a visiting psychiatrist. The project team found that the

required initial investment in the technology would discourage individual private psychiatrists from providing teleconsultation to rural areas. For this reason, they recommended that metropolitan child and adolescent mental health services employ private psychiatrists to provide teleconsultation to regional and rural areas.

3.5 Opportunity for Private and Public Practitioners to Expand their Areas of Practice

Private practitioners

Isolation in private practice can raise personal safety and security concerns when working with patients with challenging behaviours. Proximity to a public clinic can enable private practitioners to expand their practice to include patients with such behaviours. From the perspective of the practitioners, this can be professionally rewarding. In addition, such an arrangement offers an additional treatment modality for patients who might otherwise have been unable to benefit from the intensive treatment and continuity of care offered by the private sector.

The Collaborating Centre—St Vincent’s Mental Health Service (SVMHS) and St John of God Healthcare (SJOGHC).

For a number of private psychiatrists working out of the Collaborating Centre, the support of a large public hospital psychiatric service has been valuable in extending the scope of their work. As an example, the Survivors of Childhood Abuse service enjoys a profile that may not have been possible without the support of the St Vincent’s service.

Public Practitioners

A limited private practice offered within collocated settings affords public sector psychiatrists the opportunity to work with a different patient group and utilise a range of therapeutic interventions. The chance to work with patients who may not meet the admission criteria for the public mental health service, to undertake intensive therapies with individual patients or to maintain psychotherapeutic and broader diagnostic skills is highly valued by many public sector psychiatrists. The opportunity to specialise within private practice is also seen as offering significant personal and professional benefits.

3.6 Development of a Cohesive Local Approach to Mental Health Service Delivery

Models of collaboration particularly in rural areas, have the potential to facilitate the development of both a shared vision of mental health service provision in the local area and a systemic view of patient care. Collaborative initiatives can assist in resolving issues such as access to Crisis Assessment Team (CAT) services for patients of private practitioners and access for private patients to public inpatient services.

Ballarat Public and Private Psychiatrists Group (BPPPG)

One of the initial aims of the BPPPG was to resolve tensions mounting in the area over issues such as ECT, case management and the CAT Team. The Group provided a simple forum through which to discuss the issues and an agreement was reached on the approach to be taken in the area. The Group has not found the need to revisit the issues since.

The BPPPG has allowed private psychiatrists to participate in innovative developments within the public sector. For example, the public psychiatric service has forged links with University of Melbourne through the development of a Clinical Academic Unit. Private psychiatrists in the local area supported this development and were involved in shared research. In return the private practitioners have an opportunity to pursue academic and research interests that may not have been open to them without links to the public mental health service. The shared research and development activities have also assisted both sectors to contribute to more comprehensive service delivery.

South West Healthcare (Warrnambool)

The approach to service delivery in the South West area aims to create a comprehensive local system. The Director of Psychiatric Services considers that the Area Mental Health Service exists to provide short-term, specialised care for patients who enter through a single point of entry. Wherever possible, care is shared with other community services, the patient's general practitioner and private practitioners. As soon as possible, the ongoing care of the patient is transferred back into the community. Through this system, the resources of the Public Mental Health Service are only utilised for a short period of time, rather than being committed in the long term to the care of the patient. The relationship between all service providers ensures a smooth transition in cases where the patient again requires more intensive care.

4. Continuing Challenges

4.1 Change Management

As with the development of any new service initiative, concern and resistance can be met when introducing a model of collaboration. For staff of the public mental health services with strong ties to the public system, the development of linkages with the private sector can be challenging. In cases where collocated suites are developed, staff concerns can include potential additional workloads and the possibility that the private consulting suites will become a privileged part of the public mental health service. Commitment will be required by the staff from the public mental health service and private practitioners if the collaborative system is to be effective.

South West Healthcare (Warrnambool)

The success seen at South West Healthcare can be partly attributed to the commitment of the staff to complying with the procedure for service provision and undertaking extensive training. Strong leadership and clear articulation of the benefits of the collaboration were necessary elements. As with other models highlighted in this document, the involvement of senior management and administrators in driving the change was crucial to the success of the model.

Those involved in the collaborative ventures outlined in this document believe the activities undertaken have largely enhanced and improved service provision in the local area. Some concern has been raised, however, about the possibility that consumers who need the support of public sector services such as case management or assertive outreach could be inappropriately referred to the private sector. Ongoing, open dialogue and a commitment to consumer focused service provision are seen to be overcoming these tensions where they do arise.

In service provision models, it is the responsibility of both sectors to ensure that collaborative care arrangements remain dynamic and open to change. It is insufficient to establish an arrangement and lay initial concerns to rest. Promotion of the model of collaboration to staff (particularly new staff) in the public mental health service is necessary to ensure that a high standard of collaborative care is maintained. As new private psychiatrists enter the area, they should be invited by the public mental health service to become involved, so that collaboration between the sectors remains as effective as possible. Potential improvements to the arrangement will only become apparent over time, and an effort should be made to incorporate changes. When revisions are being considered, the input of private psychiatrists and public mental health staff should be sought.

4.2 Legal and Contractual Issues

In collaborative care arrangements based around service provision, it may be necessary to formulate a contract or agreement between the parties to ensure that patient responsibility and financial issues are clear. Because contractual arrangements between the public and private sector are a relatively new approach in mental health, they present a unique set of challenges.

The Carrington Consulting Suites and the Collaborating Centre

In establishing the Carrington Suites, significant consideration was given to contractual arrangements that adequately differentiated the private suites from the public mental health service. This ensured that the private suites did not place financial demands on the public service while still allowing for collaborative approaches. Similar issues were resolved in establishing the Collaborating Centre and formalising private hospital investment in a public hospital. In each of these instances the support and advice of the auspice hospital was invaluable.

The use of new technology can also raise new medico-legal issues. Videoconferencing consultations are not the same as face-to-face consultations, and inevitably involve additional people and/or agencies. Jurisdictional issues may be raised when they occur across state borders, making potential litigation more complex. It is extremely important that these issues are clarified before a project commences, and not only after the patients or practitioners involved raise concerns.

The Monash Telepsychiatry Project (Southern Health Care Network)

Finding 16: When a regional or rural service purchased consultation from another agency, service or private consultant, the issues of what exactly is to be provided and who is responsible must be negotiated and explicitly specified in the agreement or contract of employment. This includes medical indemnity, registration, prescribing, responsibility for completing medical records and case notes, case management, duty of care and dispute resolution. In the case of a contract with a private psychiatrist, this should be supported by a position description that specifies duties, responsibilities and lines of accountability. The number and nature of services to be provided, such as primary or secondary consultation, should be specified and defined.

Even in very informal models, there are sometimes legal issues which require resolution before the model can proceed.

Ballarat Public and Private Psychiatrists Group (BPPPG)

For the BPPPG one of the key challenges initially was the status of advice given in the context of the Group's meetings. Formal agreement was required that opinions given in the context of the presentation of a clinical problem did not constitute a second opinion in a medico-legal sense. The group resolved that if such a second opinion were necessary this would be handled formally through existing arrangements outside the context of the BPPPG. Resolution of such matters at the establishment of the group were considered vital in allowing the group to meet its objectives and to pre-empt and avoid potential sources of conflict.

Three monthly reports have been mentioned elsewhere in this document as a means of communication between the two sectors to ensure that collaborative care is still the most appropriate type of care for a patient. Such reports can also serve a medico-legal purpose, by making it clear that the private practitioner and public team agreed to maintain or alter the care being provided to a patient.

4.3 Demands on Organisational Resources

Collaborative service arrangements require an investment of organisational resources. When initially establishing colocated suites, significant work must be undertaken by the service managers and project staff in developing protocols and articulating how the collaborative arrangements will operate. In other cases, it will be necessary for the Public Mental Health Service to continue to contribute personnel to the project even after the initial preparatory work has been completed. For example, as the Commonwealth funding for the St Vincent's Partnership Project is for start up purposes only, the challenge remains to ensure that the Linkage Unit is cost neutral within two years.

The Carrington Consulting Suites and the Collaborating Centre

In some instances, limitations in organisational resources have also meant that the colocated suites have not yet met their full potential. Plans for shared education, joint family work and informal get togethers have all been raised as potentially useful activities and have gained considerable support from staff. However, time limits on public sector staff and private practitioners, as well as a lack of resources to organise such activities, have prevented these activities from occurring on a regular basis.

Similarly, psychiatrists working out of both St Vincent's and the Carrington Suites are keen to see the inclusion of more allied health staff at these centres. A psychologist is now part of the team at the Carrington Suites. However, the difficulties of establishing private practices in these fields, and a lack of resources to foster these practices have meant that allied health availability remains limited.

There have also been suggestions at Carrington Consulting Suites of establishing private beds within the Upton House public psychiatric inpatient unit. The developmental work required to action this has still to occur, largely due to limited time and resources.

Ballarat Public and Private Psychiatrists Group (BPPPG)

In financial terms, the BPPPG requires the least resources of any of the models referred to in this document. The commitment of clinicians in a rural area to the group has been a key to the success of this model.

4.4 Differences and Limitations of the Sectors

Cultural differences between the service sectors can present difficulties both in developing a shared understanding and at referral of an individual. Patients of both sectors may be reluctant to receive a service from the other sector. One of the best strategies for addressing this challenge is to emphasise maintaining continuity of care as much as possible. Colocated suites can assist a smooth transition from one service sector to another. For example, the proximity of the services enhances the capacity of a public practitioner to take the patient to their first private appointment and sit in on the consultation if the patient so desires.

The Carrington Consulting Suites at The Koonung Community Mental Health Centre

At the Suites a small number of referrals from the public services to the private rooms have been unsuccessful. In some cases, the patients have been unable to make the transition to an appointment based service culture. In others, the patients have been unable or unwilling to pay when they have been referred to a psychiatrist who charges a fee above the Medicare

rebate. The need to complete Medicare paperwork, even when being bulkbilled, can be a difficult transition after extensive experience of public mental health service. These unanticipated challenges are now recognised by both service sectors, and efforts are made to minimise the disruption by preparing consumers as fully as possible for the change. Where necessary, the collaborative care arrangement can be entered into in advance of a full referral.

For patients of the private sector close collaboration between the two sectors can also present challenges. Some private patients of the Carrington Suites found the collocation with the public community mental health service confronting and feared stigmatisation as a result of attending the suites.

In other cases, the greatest challenge can lie in misunderstandings between the two sectors regarding the role of public and private psychiatrists and their methods of service provision. Developing a mutual problem solving approach requires open discussion and commitment on the part of all key players.

4.5 Evaluation and Continuous Improvement

Formal, quantitative/ qualitative evaluations have not always been made of the collaborative models referred to in this document. However, the project did not intend to perform clinical trials or test a particular organizational model. Certainly, there is a sense from the participants that there are tangible benefits to the activities being undertaken. The evidence for this is, however, largely anecdotal. Factors such as reduction in the number of complaints and a perception of reduced number of inappropriate referrals all indicate that the collaborative ventures are effective, but there is no hard evidence of this causal relationship.

The Carrington Consulting Suites and the Collaborating Centre

With regard to both models of collocated suites, the investment of resources into private suites was confronting and of concern to many within the public mental health service. Initial concerns were raised about investing in the private sector when there were limited resources within the public mental health service. The experience of the two initiatives has been that they have been able to be financially self sufficient and that potentially they can ease the pressure on the public service. However, further data is required to conclusively demonstrate this assertion.

In order to further advance collaborative arrangements and to strengthen the support for collaboration among all stakeholders, efforts need to be made to collect evidence for the claims being made about their success. Some of the service providers involved have indicated that there are difficulties associated with collecting information for such purposes. The challenges of evaluation and potential solutions are outlined below. This information should be considered in conjunction with the flowcharts in the Appendix, which highlight the point at which evaluation should be considered when establishing a collaborative arrangement.

The data collection burden

It can be difficult to track an individual's movements across service sectors, particularly if appropriate data systems are not in place. The recording of information for evaluation purposes can also be time consuming, particularly given that mental health services already have a considerable data collection burden. For early evaluations, a minimalist approach to data collection is recommended, so as not to further add to the reporting burden of providers. One possibility is for evaluation data collection to be combined with existing consumer surveys. Early evaluation measures could include:

- data on the cost and type of care received, including number and type of private psychiatric consultations per patient.
- number of patients receiving care—assessing whether more patients are accessing services.
- patient, carer and staff satisfaction monitoring.
- effect of collaborative arrangements on the attitudes of public and private mental health providers.

Ethical issues

As discussed earlier in this document, collaborative care can raise patient confidentiality issues. Strict confidentiality guidelines must be established to ensure that both patient and provider confidentiality is maintained throughout any evaluation process. It is imperative that patients are informed about any evaluation process which may affect them, and that they have the option to provide or refuse their consent where this would be appropriate. Clinicians may even choose to discuss a patient's preferences about whether they want to play a role in any evaluation process when original discussions about disclosure of information take place.

Demonstrating causation

It is important to acknowledge the complexity and cost of demonstrating that a collaborative project does directly improve patient care outcomes, particularly during the early years of an arrangement. At the outset, it is recommended that evaluation be made of variables that can be more easily measured — such as continuity of care, access to services and patient satisfaction. In many ways, the views and experiences of consumers and carers are a good starting point for evaluation. No model can be claimed to have been successful unless those who use the mental health service system can see its benefits directly or indirectly.

Agreement needs to be reached between the collaborating parties about the rigor of the methodology to be implemented in the early stage evaluation. It may be the case that a balance must be struck between an expensive, broad formal evaluation study and a quicker, cheaper, less formal evaluation that may be perceived as less compelling.

St. Vincent's Mental Health Service—Public and Private Partnerships in Mental Health (Partnership Project)

The development of an evaluation strategy is a core component of the Project. The Centre for Health Program Evaluation (CHPE), University of Melbourne, has been appointed to assist with the design of the evaluation, oversee the collection and analysis of data, meet the reporting requirements of the Commonwealth and coordinate the evaluation activities with the national evaluator.

The Planning Guidelines for the National Demonstration Projects identify improved patient outcomes as the highest evaluation priority. However, given the nature and length of the Project, it is unlikely that existing measurement tools will identify direct patient outcomes. Instead, the evaluation will explore the impact of service changes on intermediate variables such as access to services and continuity of care, from which improved patient care outcomes can be assumed. The evaluation will consider equally the impact of the Project on providers and the service system.

The Partnership project will support the collection of a range of information using both quantitative and qualitative methodologies. As evaluation of the Project will also generate considerable data, issues of data access and management will also need to be addressed. Strict confidentiality guidelines will be established to ensure both patient and provider confidentiality is maintained. These issues are to be resolved with the CHPE through a memorandum of understanding.

In instances where the collaborative activities are less tangible, further consideration needs to be given to an appropriate evaluation framework. While these challenges are real, some efforts will need to be made in this regard if the value of the collaborative activities is to be demonstrated. Any evaluation undertaken should encourage the transparency of collaborative care processes by looking at outcomes for patients, providers and the system.

5. Summary

This document has sought to highlight the key principles for successful collaborative arrangements between public mental health services and provide psychiatric services. The principles were developed by identifying factors common to successful collaborative care case studies. In summary, the principles are:

- **Commitment of clinicians:** clinicians in private and public sectors must be committed to improving the quality of care offered to patients in the region by developing a better relationship between the public and private sectors.
- **Ensuring continuity of care:** there must be clear procedures for the movement of patients from one sector to another.
- **Clear communication mechanisms:** clearly defined roles, responsibilities, aims and objectives are the best strategy to ensure that all concerned receive the maximum benefit from the arrangement.
- **Appropriate remuneration for private psychiatrists:** private psychiatrists should receive recompense for their work, including, where possible, that work which does not directly involve patient consultations.
- **Planning and collocation:** even the most basic model should commence with a consideration of how collaboration can best be achieved in the area.
- **Senior managerial support:** management should not only support collaborative ventures, but should ensure that the model is championed throughout the service.
- **Obtain patient consent and assure confidentiality:** patients must give their consent before any collaborative care arrangement can commence and they should be asked to give their consent to any proposed sharing of confidential information between the sectors.
- **Take context into account:** if the collaborative arrangement is to succeed, it is important to find the right model for the right circumstances.

There are a number of possible benefits of collaboration for consumers and providers of mental health services, either through directly improving the options and services available, or through assisting providers to better meet patient's needs. Such benefits include:

- improved access to services for consumers
- improved access for providers to a wider range of knowledge and advice
- increased retention of psychiatrists within the public mental health sector
- improved care for rural patients
- opportunity for private and public practitioners to expand their areas of practice and
- the development of cohesive local approach to mental health service delivery.

It must be recognised that challenges are inevitable when implementing new service initiatives. The key challenges faced in the development of collaborative models include:

- change management requirements
- resolution of legal and contractual matters
- demands on organisational resources
- recognition of the differences between the two service sectors and the limitations of each and
- implementing processes of evaluation and continuous improvement.

The ongoing challenge facing many of those currently involved in collaborative arrangements is the need to collect valid and reliable data to support the claims that are being made about the benefits of the models. While anecdotal and impressionistic evidence for improvement is strong, quantitative and qualitative evidence is needed to better understand the models and to establish processes of continuous improvement.

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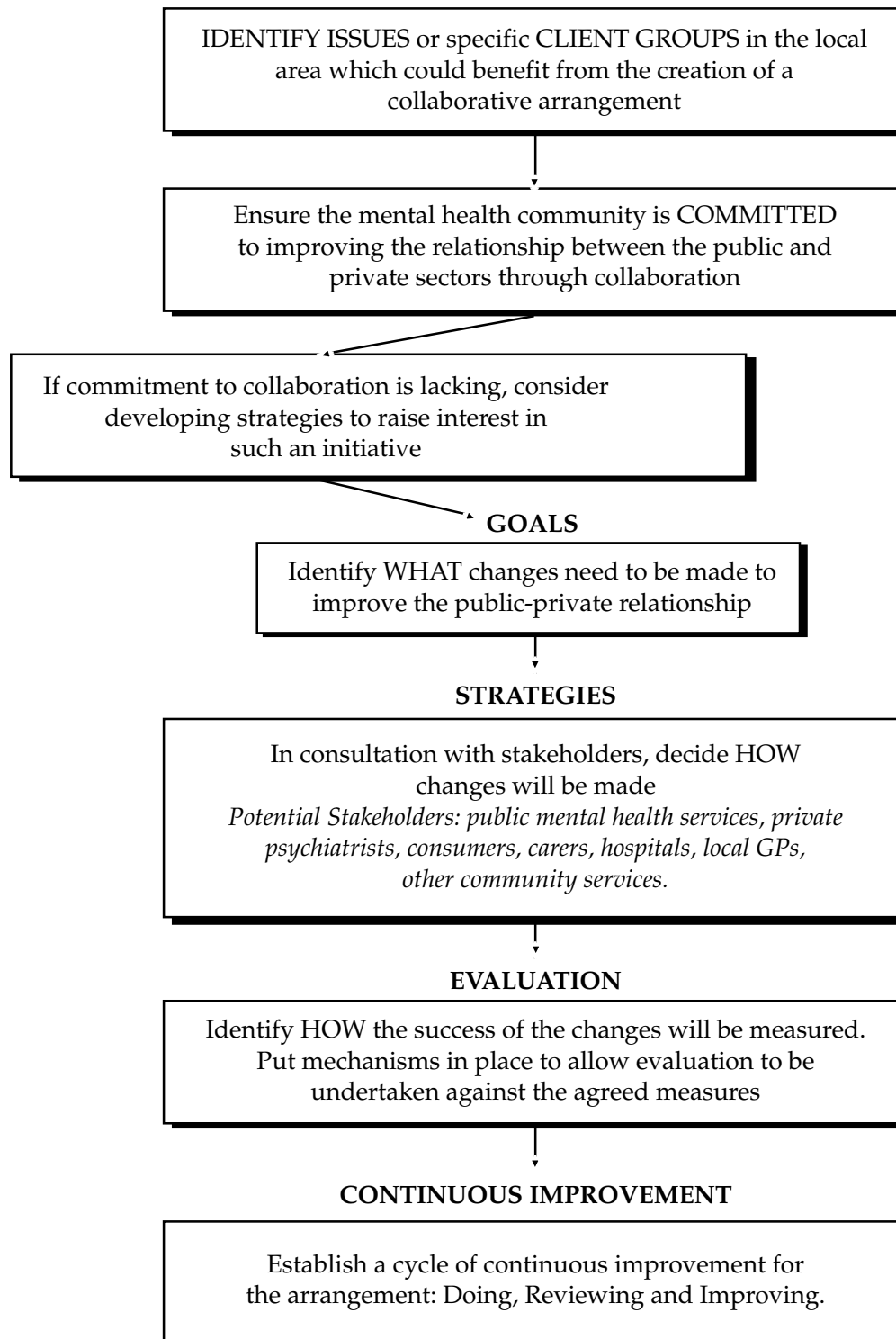
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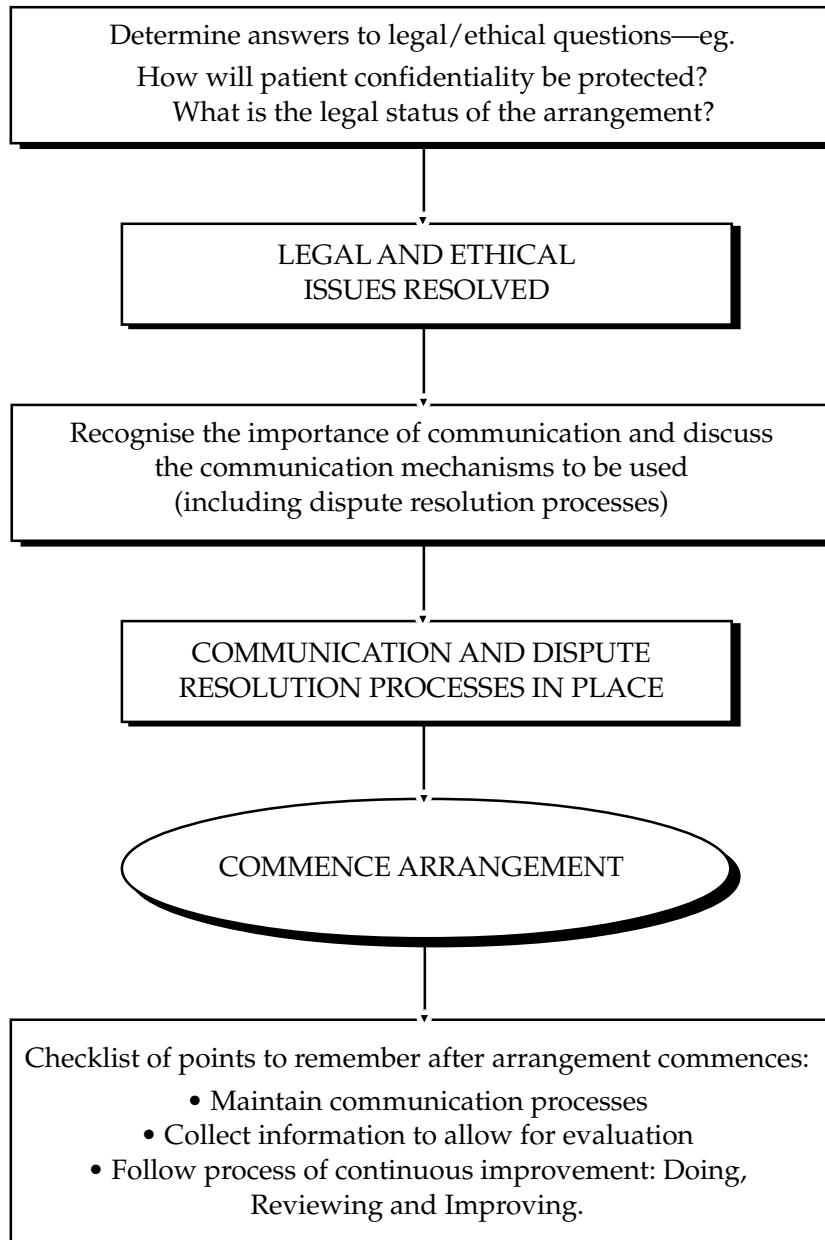
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Appendix

ESSENTIAL STEPS FOR ESTABLISHING A COLLABORATIVE CARE ARRANGEMENT



ADDITIONAL MATTERS TO CONSIDER WHEN DEVELOPING A NON SERVICE PROVISION COLLABORATIVE ARRANGEMENT



ADDITIONAL MATTERS TO CONSIDER WHEN DEVELOPING A COLLABORATIVE ARRANGEMENT BASED AROUND SERVICE PROVISION

