PMHA CDMS | THE CENTRALISED DATA MANAGEMENT SERVICE *of the* PRIVATE MENTAL HEALTH ALLIANCE

# MANAGEMENT COMMITTEE (PMHA–CDMS MC)

## FOURTH MEETING

## HELD ON THURSDAY, 28 FEBRUARY 2008

## RANZCP 309 LATROBE STREET MELBOURNE, VICTORIA

# REPORT AND RESOLUTIONS

### Glossary of Acronyms and Terms

| | |
|---|---|
| AHMAC | Australian Health Ministers Advisory Council |
| AHIA | Australian Health Insurance Association |
| APHA | Australian Private Hospitals Association |
| AMA | Australian Medical Association |
| CDMS | PMHA Centralised Data Management Service |
| CPoC | Consumer Perceptions of Care |
| DoHA | Australian Government Department of Health and Ageing |
| HCP | Hospital Casemix Protocol |
| Health Fund(s) | Private Health Insurance Fund(s) that pay benefits for psychiatric care |
| Hospital(s) | Private Hospital(s) with psychiatric beds |
| MHSC | Mental Health Standing Committee of the AHMAC Health Priorities Principal Committee |
| MHISS | Mental Health Information Strategy Sub–committee of the MHSC |
| MHQ–14 | The self–report measure being used in the private sector consisting of 14 items related to issues associated with mental and behavioural problems drawn from the SF–36. |
| National Model | The National Model for the Collection and Analysis of a Minimum Data Set with Outcome Measures for Private, Hospital–based Psychiatric Services |
| Network | Private Mental Health Consumer Carer Network (Australia) |
| PMHA | Private Mental Health Alliance |
| PMHA–CDMS MC | PMHA–CDMS Management Committee |
| RANZCP | The Royal Australian and New Zealand College of Psychiatrists |
| SQPS | Safety and Quality Partnership Sub–committee of the MHSC |

## 1. OPENING AND WELCOME

The Fourth (4th) Meeting of the Private Mental Health Alliance (PMHA) Centralised Data Management Service (CDMS) Management Committee (PMHA–CDMS MC), (the Meeting) was held on Thursday, 28 February 2008 at the Headquarters of the Royal Australian and New Zealand College of Psychiatrists (RANZCP) at 309 La Trobe Street, Melbourne.

The Chair, Dr Bill Pring, opened the Meeting at the 3:00 PM. The following representatives were in attendance.

### 1.1 Present.

| | |
|---|---|
| 1. Dr Bill Pring (Chair) | Clinicians |
| 2. Mrs Ruth Carson | Carer Representative |
| 3. Ms Moira Munro | Hospitals |
| 4. Ms Helen Eriksson | Health Funds |
| 5. Ms Janne McMahon | Consumers |
| 6. Ms Sara Khalidi | DoHA Private Health Services Branch |
| 7. Mr Allen Morris–Yates | PMHA–CDMS Director |
| 8. Phillip Taylor (Secretary) | PMHA Director |

The Secretary reported that Mr Peter Callanan from the Australian Government Department of Health and Ageing (DoHA), Private Health Services Branch was an apology and that Ms Sarah Khalidi was attending as a proxy for Mr Callanan.

### 1.2 Apologies

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|---|---|
| 1. Mr Peter Callanan | DoHA Private Health Services Branch |

## 2. REPORTS OF THE PREVIOUS MEETINGS

The Meeting considered and amended the draft Report of the Third (3rd) PMHA–CDMS MC meeting, held in Melbourne 25 October 2007.

**Resolved (unanimous)**

*That the PMHA–CDMS MC adopts the amended Report of the Third PMHA–CDMS Management Committee Meeting, held on 25 October 2007 in Melbourne, as a true and accurate record of proceedings.*

## 3. PROGRESS REPORT ON ACTIONS ARISING

The meeting then noted and updated the Table of Progress set out below.

| | AGENDA ITEMS SECOND PMHA–CDMS MC MEETING | RESPONSIBILITY | STATUS |
|---|---|---|---|
| | Report on the Third (3rd) PMHA–CDMS MC Meeting | | |
| ➢ | Draft and circulate report of 3rd PMHA–CDMS MC Meeting for comment | PMHA Director | Done |
| ➢ | Revise Report based on comments received and prepare final | PMHA Director | Done |
| ➢ | Agenda Item 4th PMHA–CDMS MC Meeting | PMHA Director | Done |
| 4 | Hospital Casemix Protocol (HCP) | | |
| ➢ | Agenda Item 4th PMHA–CDMS MC Meeting | PMHA Director | Done |
| 5 | CDMS Schedule of Services and Work Plan 2007–2008 | | |
| ➢ | Ensure flyers on training workshops are circulated to Hospitals/consumers | PMHA Director | Done |
| 6 | CDMS Services and Work Plan beyond 30 June 2008 | | |
| ➢ | Report to 3rd PMHA Meeting and 1st All Parties PMHA Meeting | Chair/CDMS Director | Done |
| ➢ | Agenda Item 4th PMHA–CDMS MC Meeting | PMHA Director | Done |
| 7 | CPoC Pilot Study | | |
| ➢ | Agenda Item 4th PMHA–CDMS MC Meeting | PMHA Director | Done |
| 8 | Mental Health Information Strategy Committee (MHISS) Report | | |
| ➢ | Agenda Item 4th PMHA–CDMS MC Meeting | PMHA Director | Done |
| 9 | Safety and Quality Partnership Working Group (SQPWG) Report | | |
| ➢ | Agenda Item 4th PMHA–CDMS MC Meeting | PMHA Director | Done |
| 11 | Next Meeting and Close | | |
| ➢ | Organise 4th PMHA–CDMS MC for 28 Feb 2008 @ RANZCP Melbourne | PMHA Director | Done |
| ➢ | Circulate Agenda and Papers | PMHA Director | Done |

## 4. PROCEDURES FOR WITHDRAWAL FROM PMHA AND ITS CDMS

The Chair reported that the meeting between the Parties to the current *Agreement for Services 2007–2008* (AMA, APHA, AHIA, DoHA, RANZCP and beyondblue) and the PMHA held on 9 November 2007 at the offices of the Federal AMA in Canberra (the All Parties PMHA 9 November 2007 Meeting) considered the issue of what protocol should be followed when a participating Hospital chooses to discontinue its financial subscription to the PMHA and its CDMS. At the request of that Meeting, the AMA sought legal advice from DLA Philips Fox concerning non–participating Hospitals and the process of notification of withdrawal. A copy of that advice, which had been circulated with the agenda and papers for this meeting, was noted.

The Chair reported that the PMHA–CDMS MC considered this advice at its first monthly teleconference, held on 20 December 2007. Based on that advice, the Management Committee drafted two *Standard PMHA Letters* for financial and non–financial Hospitals that choose to discontinue their subscription. Both draft Letters were circulated to the PMHA, amended and then endorsed out–of–session. Eight Hospitals that have discontinued their financial subscription have now been advised that the PMHA–CDMS is unable to accept or process any data submitted, or to provide those Hospitals with standard quarterly reports, revised software or manuals. The Hospitals

were further advised that any data submitted by to the PMHA–CDMS in respect of any period after 30 June 2007 would be erased upon receipt.

The Meeting considered the legal advice from DLA Philips Fox concerning non–participating Hospital that continue to submit data to the CDMS.

DLA Philips Fox advised that, if a Hospital has withdrawn from the PMHA and its CDMS by virtue of its decision not to pay the subscription for these services, then there is no obligation on the PMHA and its CDMS to accept the information submitted by these Hospitals. The relevant Hospitals were notified that they were no longer required to submit the information to the CDMS, and further, that if information was submitted, it would not be used by the CDMS and would be destroyed. Those non–participating Hospitals who have sought to submit data to the CDMS on a couple of occasions were advised by email (again) that the information could not be accepted and the information would be deleted.

DLA Philips Fox were of the view that, in terms of record keeping, it would be prudent to keep a record of the fact that information has been sent from a non–participating Hospital, and that the records were erased. Whether this is done by printing out a copy of the covering email and noting on it that the information was erased, and then erasing the email and attachment or by forwarding an email to another source noting that the information has been received but erased is a matter of choice for the individuals concerned. However, it would be appropriate for a decision to be made as to which option is to be used and a clear direction given to the CDMS Director for his information and implementation. The record keeping need go no further than this. There are no other records kept in relation to Hospitals that are not financial contributors and who do not send data to the CDMS, other than to list their names as non–participating Hospitals in the relevant CDMS and PMHA reports. A similar position could be adopted in relation to the Hospitals who are not financial contributors but who continue to submit data. It is not necessary to continue a dialogue with the non financial Hospitals who continue to send data. Those Hospitals have been informed by letter and email, at least once of the fact that their information will not be collated by the CDMS and any data submitted will be erased. It would not be reasonable for the CDMS to have to send an email each time data is submitted in these circumstances to state that the data cannot be accepted and will be erased.

Ms Helen Eriksson reported that the AHIA Mental Health Committee (MHC) felt that the Health Insurers subscription that is paid to support the PMHA–CDMS on the understanding that Health Funds will receive SQRs on all Hospitals. The SQRs for Health Insurers are now missing the data from the 8 Hospitals that have withdrawn and that data is critical to Health Insurers. Mr Morris–Yates explained that there is a possible alternative method that might address some aspects of this problem through the use of the HCP data that is submitted to Health Insurers participating in the PMHA's CDMS. Ms Eriksson will take this back to the MHC and ask that any further concerns be put to the PMHA–CDMS MC in writing.

It was noted that Health Insurers would now be liaising with those Hospitals that have withdrawn concerning their withdrawal from the PMHA and its CDMS.

PMHA–CDMS MC then considered a copy of the document titled, *Hospital Enrollment and withdrawal Procedure for the Private Mental Health Alliance and its Centralised Data Management Service* 2008, which had been revised to be consistent with the legal advice from DLA Philips Fox. Following further amendment, it was recommended that the Procedure be referred to the PMHA for endorsement.

**Resolved (unanimous)**

1. *That the PMHA–CDMS MC requests that when a non–participating hospital seeks to submit data to the CDMS the PMHA–CDMS Director advise that facility that the information cannot be accepted by the PMHA–CDMS and that the information will be erased. The PMHA–CDMS Director must forward a copy of that advice to the PMHA Director for inclusion in the records of the Federal Office of the Australian Medical Association, which is responsible for the PMHA–CDMS under the AMA Agreement for Services 2007–2008.*

   ***Action: PMHA–CDMS Director/PMHA Director***

2. *That the PMHA–CDMS MC requests that the PMHA endorse the document titled, Hospital Enrollment and withdrawal Procedure for the Private Mental Health Alliance and its Centralised Data Management Service 2008.*

   ***Action: PMHA–CDMS MC Chair***

## 5. HOSPITALS CASEMIX PROTOCOL (HCP)

The PMHA Director explained that the All Parties PMHA 9 November 2007 Meeting requested that the PMHA–CDMS Director, together with appropriate representatives from the APHA and AHIA, meet with the Australian Government in an effort to resolve the issues related to coding and the Hospital Casemix Protocol that are critical to the update of the HSMdb software for Hospitals and the re–building of the Data Warehouse.

Since that request was made, DoHA released a Private Health Insurance Circular concerning the consultation on the changes to the HCP that will take effect from 1 July 2008. DoHA was seeking comments by Friday, 22 February 2008. In response, the PMHA–CDMS Management Committee convened an urgent HCP teleconference on 14 February 2008 between Mr Morris–Yates, Health Funds and Hospital representatives to develop a PMHA submission on the HCP for DoHA.

### 5.1 PMHA Submission on the HCP

The PMHA Submission was forwarded to Ms Louise Clarke, Assistant Secretary of the DoHA, Healthcare Services and Financing Branch on 20 February 2008. The concerns raised in the Submission are set out below.

There are fundamental inconsistencies between HCP–1 and HCP–2 data sets, whereby HCP–2 appears to be missing key information that is routinely recoded under HCP–1.

Under HCP–1 records of episodes of care capture information about admitted patients' needs for care (Diagnoses), the type of care and services they received (Care type, Procedures, MBS Items, Miscellaneous Services), the quantum of services provided (e.g., Total leave days, ICU days, Palliative care days, Coronary care unit days, Total psychiatric care days, Hospital in the home care days, Number of hospital in the home care visit days) and the charges associated with the provision of those services (e.g.,

Accommodation charge, Accommodation benefit, Intensive care unit charge, Intensive care unit benefit, Other charges, Other benefits, etc.).

In aggregate those four domains – Needs for care, Type of care and services, Quantum of services provided and Costs of services – may be used to comprehensively describe "Who receives what services from whom at what cost". HCP–1 also includes some information that enables patients' clinical paths to be identified (Source of referral, Provider number of hospital from which transferred, Inter–hospital contracted patient, Discharge intention on admission, Mode of separation and Provider number of hospital to which transferred). Putting aside the problems raised when people change health funds, the linkage of these records by Payers and the Australian Government enables a reasonably comprehensive clinical history of each member to be assembled, enabling aggregate analyses of patients' progression along various clinical paths.

Under HCP–2 records of Service Events capture substantially less detailed information about the five domains mentioned above for non–admitted patients. Table 1 identifies the similarities and differences between the two record sets

As can be seen, HCP–2 only provides complete information about the cost of services provided in a given period. Some coarse information about the nature of the services provided could be derived from Service speciality. Service codes have the potential to provide very useful information. But they are limited by the fact that there is no common classification system. Accordingly, comparison across different Payers may be very problematic. The lack of information about patients needs for care, beyond that indicated by the Service speciality code means that within service specialities it will be impossible to undertake casemix adjustment of variations in Costs of services. Furthermore, there is no reliable information recorded about the actual quantum of services provided, so all analyses will be restricted to the Costs of services.

HCP–2 also lacks any means of specifying what place in the sequence of care an identified Service event occupies. This is particularly important where the episode of non–admitted patient care extends over a period of several months, potentially giving rise to two or more Service event records for the one underlying clinical episode of care.

Partial information about that matter could be derived by linking each patient's set of HCP–1 and HCP–2 records together as a sequential list and then imputing each Service event's clinical place in the sequence of care on the basis of the combined details of the event itself and those of the immediately preceding and following episodes or events. The accuracy of operation of such complex algorithms and the utility of the information derived from subsequent analyses would be greatly facilitated by some coded information regarding the Reason for service event start and Reason for service event finish.

Table 1: Comparison of HCP–2 with HCP–1.

| | | | |
|---|---|---|---|
| *Needs for care* | | | |
| HCP–1 | HCP–2 | | Comment |
| Diagnoses | | X | No information except that weakly implied by Service speciality |
| *Type of care and services provided* | | | |
| HCP–1 | HCP–2 | | Comment |
| Care type | Service speciality | ~ | Conceptually equivalent |
| Procedures | | X | No equivalent |
| MBS Items | | N | Billed separately |
| Miscellaneous services | Service codes | ~ | Field definition is not consistent, however the data element definition suggests they are conceptually equivalent |
| *Quantum of services provided* | | | |
| HCP–1 | HCP–2 | | Comment |
| Hospital in the home care days | Service event end date, Service event start date | ✓ | Duration of the service event may be derived |
| Hospital in the home care visit days | | X | No equivalent |
| *Cost of services* | | | |
| HCP–1 | HCP–2 | | Comment |
| Multiple fields from which Total charges and Total benefits may be derived | Service event charge, Service event benefit | ✓ | Technically equivalent |
| *Clinical path* | | | |
| HCP–1 | HCP–2 | | Comment |
| Source of referral | | X | No equivalent |
| Mode of separation | | X | No equivalent |

The PMHA Submission recommended that, at the very least, the following data elements should be added.

- **Diagnoses** (Consistent with Service codes, we suggest that 8 diagnosis fields be included)

- **Number of treatment days** (the number of days on which the person actually received a service, not the duration of the service event, which may be the same as or longer than the Number of treatment days)

The Submission further recommended that, if the HCP–2 data element Service codes are in fact conceptually equivalent to the HCP–1 data element Miscellaneous service codes, then the definition of the Service code field in HCP–2 should be made consistent with that of Miscellaneous service code in HCP–1. That is, change the Type and size of **Service code** to A (11). It was also suggested that, if agreement on an appropriate domain (classification scheme) for each could be reached in time, it would be useful to add two data elements – **Reason for service event start** and **Reason for service event finish**.

The Meeting discussed the Submission and agreed that the unique nature of mental health area is not fully understood particularly in relation to psychiatric outreach services.

It was agreed that the the PMHA should be asked to write to Ms Clarke requesting clarification as to how psychiatric outreach services are perceived.

**Resolved (unanimous)**

*That the PMHA–CDMS MC requests that the Chair ask the PMHA to write to Ms Louise Clarke, Assistant Secretary of the DoHA, Healthcare Services and Financing Branch requesting clarification as to whether psychiatric outreach care will occur under the HCP along similar lines to Example 4, which appears under the Australian Government circular PHI 05/08. If that is the case, then the PMHA should seek clarification as to what the Admitted Patient of the Hospital–in–the–Home is and whether an example can be provided of that.*

***Action: PMHA–CDMS MC Chair***

## 6. PERTH CLINIC PRESENTATION

Ms Moira Munro provided a short presentation on a successful project that was funded by Medibank Private that utilised touch screen technology to enable patients at Perth Clinic to enter data during their course of Cognitive Behavioural Treatment (CBT). The software makes it possible to track graphically how the patient is progressing with their CBT, and for that to be feedback rapidly to the clinical staff. Copies of the presentation are available from Ms Munro on request.

## 7. CDMS SCHEDULE OF SERVICES AND WORK PLAN 2007–2008

The PMHA Director reported that the All Parties PMHA 9 November 2007 meeting had considered the document titled *Provision of CDMS Services now and in the Future*, prepared by PMHA–CDMS Director, Mr Allen Morris–Yates. At that meeting, Mr Morris–Yates spoke to this document and reported on the provision of CDMS services that were on schedule and those that will be delayed beyond the expiration of the *AMA Agreement for Services 2007–2008* on June 30 2008. In response, the meeting requested that the PMHA–CDMS Management Committee meet via teleconference on a monthly basis to:

a) more actively engage in the management of the PMHA's CDMS; and

b) to determine what options are available to resolve the delay with the provision of the CDMS services that were scheduled for delivery before 30 June 2008.

PMHA–CDMS MC adopted the report of its first monthly teleconference held on 20 December 2007. The report of the second monthly teleconference held on 1 February 2008 was adopted, following minor amendment to reflect that SQRs had been delayed due to the necessity to correct errors in the data submitted by Hospitals.

Mr Morris Yates provided a presentation on the HSMdb Data warehouse and tabled the following update.

## 7.1 Update regarding the CDMS Work Plan to June 2008

The original work plan for the CDMS in the period from January 2007 through to June 2008 was framed during the negotiations over the future of the SPGPPS in late 2006. Some of the assumptions on which that plan was based and the timelines it laid down have since been found to be unrealistic. Also, the uncertainty regarding the future of the PMHA and the CDMS has prompted a refocussing of short–term objectives for the CDMS.

Leading up to June 2008, the work of the CDMS is being directed towards the delivery of resources that may assist Hospitals' with their ongoing implementation of the National Model, with less focus on re–development of the CDMS's analysis and reporting capacity.

The major components of the work completed or being currently undertaken by the CDMS during the period from January 2007 to June 2008 are outlined in the table below and then described in greater detail following.

| | | | |
|---|---|---|---|
| 1. | Preparation and distribution of Standard Quarterly Reports for Hospitals and Payers based on data submitted to the CDMS by participating Hospitals. | Ongoing, generally on schedule | |
| 2. | Development of an SQR data extract format for both Hospitals and Payers that would enable them to import the aggregate statistical information contained in the Standard Quarterly Reports into other software tools. | Completed | Apr 2007 |
| 3. | Revision of the Training Resources and Manuals provided to Hospitals. | Completed | Nov 2007 |
| 4. | Revision of the CDMS Data Warehouse and conversion from MS Access 2003 to MS SQL Server 2005. | Phase one nearly completed | Mar 2008 |
| 5. | Revision and enhancement of the HSMdb software provided to Hospitals. | Start in April 2008 | Jun 2008 |

1. **Preparation and distribution of Standard Quarterly Reports for Hospitals and Payers based on data submitted to the CDMS by participating Hospitals.** This is the CDMS's primary task. Reports due to be distributed in March 2007, June 2007 and September 2007 were all distributed on schedule. As in previous year of the CDMS's operation, reports scheduled to be prepared and distributed in December 2007 were delayed, with distribution being completed at the end of January 2008.

2. **Development of an SQR data extract format for both Hospitals and Payers that would enable them to import the aggregate statistical information contained in the Standard Quarterly Reports into other software tools.** This work was completed in the 1st half of 2007. An extract of the "data cubes" on which the SQRs are based is provided to both Hospitals and Payers in a fully documented XML data format. To assist Payers with the use of their extracts, and SQR Viewer application was developed in MS Access 2003 and is now provided on the SQR distribution discs to all Payers. This complements the existing analysis tools built into the HSMdb software provided to Hospitals.

3. **Revision of the Training Resources and Manuals provided to Hospitals.** This work was originally scheduled to be completed in the 1st half of 2008, but was brought forward to enable updated materials to be used in training staff from two newly enrolled Hospitals. The revisions were principally designed to address problems that have become apparent in the collection of the two clinical measures, the HoNOS and MHQ–14. New versions of the *Implementation Guide*, *Hospital Staff Trainers Manual*, *Vignettes and HoNOS Glossaries for Use in Training*, *Guide for Hospital Staff*, and the *HSMdb System Users Guide*, together with electronic versions of the presentations used in training were prepared. These were packaged in kit form and distributed to all participating Hospitals during the 2nd half of 2007.

4. **Conversion of the CDMS Data Warehouse from MS Access 2003 to MS SQL Server 2005.** The principle reason for undertaking this work is to address storage limitations in all versions of MS Access and revise the underlying model of episodes of care used within the Data Warehouse. The original work plan specified that this work be completed by the end of June 2008. However, for various reasons, both the timeline and strategy for completing the conversion have had to be revised. In the 1st quarter of 2008 three related pieces of work will be undertaken. First, the existing data cleaning and linkage functions within the existing MS Access 2003 version of the Data Warehouse will be revised and enhanced. (This work was completed in January 2008.) Second, both the front–end interface and back–end data storage of the Data Warehouse will be converted from MS Access 2003 to MS Access 2007. Finally, the back–end data storage will be converted from MS Access 2007 to MS SQL Server 2005. With the completion of this work the problems caused by the storage limitations of MS Access will have been overcome. This work is on–track and will be completed in mid March 2008. As there are some significant differences between MS Access 2003 and the combination of MS Access 2007 and MS SQL Server 2005, that new version of the Data Warehouse will not be employed in the preparation of the Standard Quarterly Reports until its' outputs have been comprehensively compared with those from the existing operational version. It is expected that the new version of the Data Warehouse will be employed in the preparation of the reports for the 3rd Quarter of 2007–2008 during June 2008.

5. **Revision and enhancement of the HSMdb software provided to Hospitals.** The changes to the HCP format introduced in July 2006 added substantially to the volume of data contained within the HCP data set. The number of data elements increased from approximately 100 to 180 data elements. This increase in the storage requirements and the incremental increase in the volume of data recorded within HSMdb over time has resulted in a degradation of HSMdb's performance, particularly in Hospitals where the HSMdb data file is located on a file server. Hospitals have indicated that increasing problems with the speed with which HSMdb is able to perform certain important functions makes the task of importing and linking HCP data with the data recorded in HSMdb unreasonably difficult and time consuming. Those problems also affect the use of HSMdb's local data analysis functions. The focus of the revisions to HSMdb will therefore be on improving the speed and utility of the HCP data linkage and Episode assembly functions. Time permitting, enhancements to HSMdb's capacity to analyse and report on episodes of Ambulatory Care will also be made. A revised and possibly enhanced version of HSMdb will be made available to all participating Hospitals at the end of June 2008.

At the request of the Meeting, the PMHA Director emailed the above update provided by Mr Morris–Yates to Ms Christine Gee and Mr Paul Mackey for consideration for distribution to Hospitals.

## 8. CONSUMER PERCEPTIONS OF CARE (CPoC) PILOT STUDY

Mr Morris–Yates reported that the collection phase of CPoC was completed in both the private and the public sectors in 2006. The following reports were due to be provided by 31 December 2006.

- A draft aggregate report for private hospitals for consideration by the APHA Psychiatry Sub–committee.
- A draft aggregate report for Queensland Health.
- A report for the Australian Government. It is anticipated that this will be the report for release to the public domain, albeit at the discretion of the Australian Government

The CPoC was discussed and Consumers, Carers and Hospitals expressed frustration over the delay with these reports. Mr Morris–Yates indicated that it is anticipated that these final reports would not be available until the end of 2008.

## 9. MENTAL HEALTH INFORMATION STRATEGYS SUB–COMMITTEE (MHISS)

The private sector representative on the MHISS, Ms Moira Munro, reported that she attended the last MHISS meeting held on 7/8 February 2008 in Perth. A copy of the Agenda for that meeting was circulated with the agenda and papers for this Meeting. It was noted that the agenda was not for citation or circulation beyond the PMHA.

### 9.1 Mental Health Intervention Codes

Ms Munro reported that the major issue for the private sector remains the National Mental Health Intervention Codes (MHIC). MHISS agreed that only one of these codes will be implemented and included in the 2008 publication of the *Australian Classification of Health Interventions*. The other codes were taken back for further review as they proved unworkable at trial. The Australian Government has commissioned the Australian Institute of Health and Welfare (AHIW) to take this work forward and an AHIW reappraisal study of MHIC is underway.

### 9.2 AHIW Collaborative Project – Tracking suicide trends in Australia

The National Injury Surveillance Unit (NISU), a collaborative unit of the AIHW and the Mental Health Services Unit will be working collaboratively on this DoHA funded project. The purpose of this review is to investigate the current methods by which suicide is enumerated in Australia and to propose a model which will highlight best practice guidelines for improved reporting of suicide in Australia. As the rate of suicide in Australia is a outcome measure in COAG's National Action Plan on Mental Health 2006–2011, it is vital that data underpinning the indicator are both valid and reliable and that the systems in place within key processing and reporting components are as efficient as possible.

A preliminary report into the factors contributing to under enumeration of suicide in Australia was completed in November 2007, and work has commenced on the construction and application of a model to improve the measurement of suicide in Australia, based on the information gathered in the second stage of the project, combined with analysis of available data. A draft report on this stage of the project will be delivered to DoHA in early 2008.

A final report will be completed in March 2008 that will assess the usefulness of the model and recommend a series of best practice guidelines for the future reporting of suicide in Australia. These recommendations will focus on suggested improvements to the system for recording and classifying suicide deaths. The final report will be published as an AIHW publication.

## 10. SAFETY AND QUALITY PARTNERSHIP SUB–COMMITTEE (SQPS)

The Meeting noted a copy of the draft minutes of the meeting of the SQPS held on Friday, 19 October 2007 in Melbourne and a copy of the draft agenda for the next SQPS to be held on Friday, 14 March 2008 in Adelaide. The Chair reported that the 14 March SQPS meeting is being held to coincide with the SQPS 12/13 March 2008 Second National Forum on Seclusion and Restraint. ACT Mental Health is organising the Forum, which will provide project participants the opportunity to present their learnings, discuss their progress achieved to date, assist in identifying the next steps and planning for the National Forum that has been scheduled for 15 May 2008.

After discussion it was agreed that the PMHA Director would attend the 14 March SQPS meeting on behalf of Dr Pring who would be overseas at that time. It was further agreed that PMHA representatives would be encouraged to attend the National Forum scheduled for 15 May.

The PMHA–CDMS MC noted the following items from the 19 October 2007 SQPS meeting.

***Review of National Standards for Mental Health Services*** The Australian Council on Healthcare Standards (ACHS) is the contracted organisation developing the revised Standards which are due for completion in May 2008. The ACHS released the second draft of the revised standards for field review from 25 September to 18 October 2007. Desk top audits were also conducted between 26 September 2007 and 24 October 2007. SQPS members were invited to participate in these activities. The ACHS advised that the pilot surveys would be conducted with a revised version of the Standards incorporating feedback from the field review and desk top audits in phase three of the Review. Phase three of the Review was due to commence 30 January 2008.

Ms Janne McMahon discussed some of the difficulties being experienced with this Review.

***Seclusion and Restraint Working Party*** The Seclusion and Restraint Working Party (SRWP) has agreed a definition for seclusion, and national principles underpinning the use of seclusion have been endorsed. The SRWP has also commenced working on the development of the performance indicator for restraint. The work completed by the SRWP on seclusion was considered at the first meeting for the National Seclusion and Restraint Project held on 16 November 2007.

***National Projects for the Reduction of Seclusion and Restraint*** The National Mental Health Seclusion and Restraint Project was developed as a collaborative initiative between the Australian and state and territory Governments. The Project will develop and test resources that can be used to support long term change in workforce culture and practice leading to a reduction, and where possible, an elimination of seclusion and restraint in public mental health services. The Project comprises of three parts:

National Documentation Project – comprising of a Community of Practice network and the development and piloting of data standards and performance indicators.

Beacon Demonstration Sites – all state and territory jurisdictions are participating in the Beacon Demonstration Sites Project. Eleven sites across Australia will develop and implement best practice initiatives. These sites aim to become centres of excellence in relation to the reduction and, where possible, the elimination of seclusion and restraint.

Study Tour Scholarships – funding has been awarded for 18 study tour scholarships, including project staff, and consumer and carer representatives. The scholarships are to identify evidenced based practice at facilities in the United States of America and to adapt these learnings to the Australian environment.

By the end of 2007 the study tours awarded to scholarship holders in New South Wales, Victoria, Queensland, South Australia and Tasmania had been completed. The remaining scholarship holders in the Australian Capital Territory, the Northern Territory and Western Australia will conduct their study tours in late January and early February 2008.

***Reducing Suicide and Deliberate Self Harm in Mental Health Services.*** The Australian Government undertook to progress work in relation to this priority in early 2007. To initiate the work, state and territory participants of the SQPS were to submit copies of their suicide risk assessment tools, policies and procedures to the Australian Government in order to create a national resource. Conflicting priorities have resulted in further work not being progressed by the Australian Government with the exception of collating the resources on risk assessment, of which not all jurisdictions provided input. An examination of the materials submitted has revealed the need to undertake a more comprehensive search of relevant documentation produced nationally. The Australian Government has undertaken to progress this item in 2008.

***Safe Transport Principles.*** A revised version of the draft Safe Transport Principles has now been endorsed by the SQPS and was submitted to the Mental Health Standing Committee (MHSC) in mid November 2007 for consideration out–of–session.

***2008 SQPS Meetings*** The next face–to–face SQPS meeting will be held on 14 March 2008. Subsequent meetings are scheduled for 20 June and 24 October 2008.

## 11. NEXT MEETING

It was agreed that the next face–to–face meeting of the PMHA–CDMS MC will be held to coincide with the next face–to–face meeting of the PMHA. It was agreed that

the next monthly teleconference of the PMHA–CDMS MC would be held on Monday 31 March 2008 at 12 Noon. There being no further business, the meeting closed at 6:00 PM.

Dr Bill Pring
Chair

Mr Phillip Taylor
Secretary