PMHA | PRIVATE MENTAL HEALTH ALLIANCE

TWENTIETH (20TH) MEETING

HELD ON FRIDAY, 5 JULY 2013

AT

ADELAIDE CLINIC
33 PARK TERRACE
GILBARTON
SOUTH AUSTRALIA

REPORT OF MEETING

Glossary of some common acronyms and terms regularly used in this report

ABF	Activity Based Funding
ACSQHC	Australian Commission on Safety and Quality in Healthcare
AHMAC	Australian Health Ministers Advisory Council
AMA	Australian Medical Association
APHA	Australian Private Hospitals Association
BPD	Borderline Personality Disorder
COAG	Council of Australia Governments
CPoC	Consumer Perceptions of Care
Commonwealth	The Australian Government
DoHA	Australian Government Department of Health and Ageing
FY(s)	Financial Year(s)
HCP	Hospital Casemix Protocol
Hospital(s)	Private Hospital(s) with psychiatric beds
HSMdb	Hospitals Standardised Measures database application of the CDMS
MHSC	Mental Health Standing Committee of the AHMAC Health Priorities Principal Committee
MHISS	Mental Health Information Strategy Sub–committee of the MHSC
Network	Private Mental Health Consumer Carer Network (Australia)
NSMHS	National Standards for Mental Health Services
PHA	Private Healthcare Australia (formally Australian Health Insurance Association)
PMHA	Private Mental Health Alliance
PMHA–CCMWG	PMHA Collaborative Care Models Working Group
PMHA–CDMS	PMHA Centralised Data Management Service
SQPS	Safety and Quality Partnership Sub–committee of the MHSC

1 OPENING AND WELCOME

The Independent Chair of the Private Mental Health Alliance (PMHA or Alliance), Mr Philip Plummer, opened the Twentieth (20th) meeting of the PMHA (the Meeting) at 9:00 AM on Friday, 5 July 2013 in Adelaide. The Meeting was kindly hosted by the Adelaide Clinic, 33 Park Terrace, Gilberton, in South Australia. The following representatives were in attendance.

1.1 Present

Independent Chair

1. Mr Philip Plummer	PMHA Independent Chair

Consumers and Carers

2. Ms Janne McMahon	Consumer Representative Chair, Private Mental Health Consumer Carer Network (Australia) [Network]
3. Mr Patrick Hardwick	Carer Representative Network Deputy Co–chair

Providers

4. Dr Choong–Siew Yong	Australian Medical Association (AMA)
5. Dr Bill Pring	AMA
6. Ms Moira Munro	Australian Private Hospitals Association (APHA)
7. Ms Carol Turnbull	APHA

Payers

8. Ms Andrea Selleck	Private Healthcare Australia (PHA)
9. Ms Helen Eriksson	PHA
10. Ms Helen Marx	Australian Government Department of Health and Ageing (DoHA) Quality Improvement, Data and Reporting System Improvement Branch
11. Mr Jonathon Wauer	Australian Government Department of Veterans' Affairs (DVA)

Staff

12. Mr Morris–Yates	PMHA–CDMS Director
13. Phillip Taylor	PMHA Director (Secretary)

1.2 Apologies

1. Mr Matthew Jackson DVA (proxy Mr Jonathon Wauer)

1.3 Invited Guests (from Morning Tea until Luncheon)

1. Mr Frank Quinlan CEO, Mental Health Council of Australia (MHCA)
2. Mr Josh Fear MHCA, Director of Policy and Projects

2. REPORT OF THE LAST PMHA MEETING

The PMHA adopted the report of its last meeting.

Resolved (unanimous)

That the Private Mental Health Alliance (PMHA) adopts the Report of the Nineteenth PMHA Meeting held on 8 March 2013 in Canberra, as a true and accurate record of proceedings and directs that the Report be made available on the PMHA website at: www.pmha.com.au.

Action: PMHA Director

3 PROGRESS REPORT AND PMHA WORKPLAN

3.1 Table of Progress on Matters Arising from the 19th PMHA Meeting

The Meeting updated the Table of Progress on Matters Arising from the last meeting.

#	TABLE OF PROGRESS	RESPONSIBILITY	STATUS
2	PMHA MEETING REPORTS		
	Post Report of 18th PMHA Meeting on PMHA Website	PMHA Director	Done
	Draft and circulate for comment Report of 19th PMHA Meeting held on 8 March 2013.	PMHA Director	Done
	Revise Report of 19th PMHA Meeting and prepare final.	PMHA Director	Done
	Agenda Item 20th PMHA Meeting.	PMHA Director	Done
3	PROGRESS REPORT AND WORKPLAN 2011–12		
	Agenda Item 20th PMHA Meeting	PMHA Director	Done
4	AMA FINANCIAL STATEMENTS		
	Agenda Item 20th PMHA Meeting	PMHA Director	Done
5	PMHA COLLABORATIVE CARE MODELS WORKING GROUP		
	Agenda Item 20th PMHA Meeting	PMHA Director	Done
6	PMHA QUALITY IMPROVEMENT PROJECT (QIP) STEERING COMMITTEE REPORT		
	Agenda Item 20th PMHA Meeting	PMHA Director	Done
7	PMHA CENTRALISED DATA MANAGEMENT (CDMS) REPORT		
	Agenda Item 20th PMHA Meeting	PMHA/CDMS Directors	Done
8	FUTURE OF THE PMHA, ITS CDMS AND THE PMHCCN		
8.1	AMA Agreement for Services 2013–15		
	Prepare AMA Agreement for Service 2013–15 for Execution on or before 1 July 2013	PMHA Director	Done
8.3	PMHA, CDMS and Network Work Plans FYs 2013–15		
8.3.2	CDMS Work Plan FYs 2013–15		
	Prepare a proposal for consideration by PMHA for work the CDMS might undertake in FY 2014–15 in two areas:	CDMS Director	Pending
	(1) Classification of cases, beyond the current principle diagnosis classification used by the CDMS.		
	(2) The identification of Hospitals that are performing well in terms of clinical outcomes.		

#	TABLE OF PROGRESS (continued)	RESPONSIBILITY	STATUS
8.3.3	PMHCCN Work Plan FYs 2013–15		
	Explore establishing a system for receiving donations and nominal membership fees via the PMHCCN website.	PMHCCN Chair/PMHA Director	Done
	Agenda Item 20th PMHA Meeting	PMHA Director	Done
9	PRIVATE MENTAL HEALTH CONSUMER CARER NETWORK (NETWORK) REPORT		
9.1	Network Governance 2013–15		
	AMA to revise Network Governance Documents and ensure the following	Dr Pring/AMA	Done
	The nature of the relationship between the AMA, PMHA and the PMHCCN is more clearly set out.	Dr Pring/AMA	Done
	Clarify who the Network Chair is responsible to in the Position Description for the Network Chair.	Dr Pring/AMA	Done
	Clause 7 of the Operating Guidelines deals properly with misconduct and removal of members.	Dr Pring/AMA	Done
	Include performance management for Network Office Bearers	Dr Pring/AMA	Done
	Term of Office for Network Chair is in line with each AMA Agreement with reappointment assessed at the end.	Dr Pring/AMA	Done
	All the Position Descriptions to be clear who PMHCCN Office Bearers are appointed by.	Dr Pring/AMA	Done
	Revise PMHCCN Code of Behaviour to clarify who it applies to.	Dr Pring/AMA	Done
	Seek legal opinion on whether there is a need to obtain Police Checks for PMHCCN Office Bearers.	Dr Pring/AMA	Done
	Acknowledge that the PMHA Independent Chair membership of the PMHCCN–NC in relevant documents.	Dr Pring/AMA	Done
	Proceed with negotiations to fund the Project	PMHCCN Chair	Done
	Review Project Brief and include iterative process between the Project and the PMHA's CCMWG	PMHCCN Chair	Done
	Agenda Item 20th PMHA Meeting	PMHA Director	Done
10	PMHA COMMUNICATION		
	Circulate 14th PMHA Newsletter for approval via email by PMHA	PMHA Director	Done
	Circulate approved 14th Edition electronically in April 2013	PMHA Director	Done
	Agenda Item 20th PMHA Meeting	PMHA Director	Done
11	MENTAL HEALTH DRUG AND ALCOHOL PRINCIPLE COMMITTEE		
	Agenda Item 20th PMHA Meeting	PMHA Director	Done
11.1	MHISSC REPORT		
	Attend MHISS 21/22 March 2013	Ms Munro	Done
	Attend MHISS 6/7 June 2013	Ms Munro	Done
	Invite MHCA CEO and MHCA Director of Policy and Projects to attend a meeting of the PMHA.	PMHA Director	Done
	Agenda Item 20th PMHA Meeting	PMHA Director	Done
11.2	SQPSC REPORT		
	Attend SQPS 15 March 2013	Dr Pring	Done
	Agenda Item 20th PMHA Meeting	PMHA Director	Done
13	OTHER BUSINESS		
13.1	Scoping project on recognising and responding to deterioration in a person's mental state (Project)		
	Participate in a collaboration tendering for Project.	PMHA/CDMS Directors	Done
	Agenda Item 20th PMHA Meeting	PMHA Director	Done
14	NEXT MEETING		
	Organise 20th PMHA Meeting to be held on 5 July 2013 in Adelaide	PMHA Director	Done
	Prepare and circulate Agenda and Papers for 20th PMHA Meeting	PMHA Director	Done

3.1.1 Future of the PMHA, its CDMS and the PMHCCN

The PMHA Director, Mr Phillip Taylor, reported that since the last PMHA meeting the *AMA Agreement for Services 2013–15* (Agreement) had been fully executed to enable the activities of the PMHA, its Centralised Data Management Service (CDMS), and the Private Mental Health Consumer Carer Network Australia (Network or PMHCCN), to continue from 1 July 2013 to 30 June 2015 (FYs 2013–15).

The Parties to this Agreement are the AMA, APHA, PHA and the Australian Government. Beyondblue is not a Party to this Agreement as they are no longer providing core funding support for the Network. Over the past 12 months beyondblue has been implementing a new strategic plan under which it will no longer be providing funding support for representative bodies, such as the Network. Beyonblue has recognised that this strategic change has come at a time when funding for the Network was being co–ordinated for FYs 2013-15. In light of this, beyondblue has provided a

transitional donation of $10,000 to support the Network in FY 2013–14 while it adjusts its activities to be in line with its revised core funding.

In addition, the AMA and its Legal Policy Adviser completed a review of the Network's governance documents for FYs 2013–15 in consultation with Dr Bill Pring and the PMHCCN Executive. The review took into account the comments of the last meeting of the PMHA as detailed in the minutes of that meeting under Agenda Item 9.1. The following documents were subsequently accepted by the PMHCCN Executive and endorsed by the PMHA out–of–session.

1. Position Description Network Chair
2. Position Description Network Deputy Chairs
3. Position Description and Nomination Process Network State Coordinators
4. Information for Consumer and Carer State Advisory Forum Participants
5. Network Code of Behaviour
6. Network Operating Guidelines 2013–15

The PMHA query from the last meeting as to whether there is a need to obtain Police Checks for Network Office Bearers, was also addressed in detail via email with the AMA advising that, on balance, this is not a situation where you would normally have criminal history checks done on office bearers. The PMHCCN revised Code of Behaviour for Office Bearers and the AMA Code of Behaviour for Appointees (now reflected in the above documents) would most likely cover any inappropriate behaviour that might come to light after they take office.

Mr Taylor reported that the AMA, APHA, PHA, the Australian Government and the Network have confirmed that their representatives on the PMHA for the term of the Agreement as follows.

AMA	Dr Choong Siew–Yong and Dr Bill Pring
APHA	Ms Moira Munro and Ms Carol Turnbull
PHA	Ms Andrea Selleck and Ms Helen Eriksson
Australian Government	Ms Helen Marx (DoHA) and Mr Matthew Jackson (DVA)
Network	Ms Janne McMahon and Mr Patrick Hardwick

The AMA has also confirmed that the Independent Chair for the PMHA, Philip Plummer, and the Network Chair, Janne McMahon have been re–appointed for the term of the Agreement. The AMA has issued the necessary Letters of Offer for staff and office bearers of the PMHA, its CDMS and the Network. During the course of the meeting the PMHA conducted an election and Ms Moira Munro was re–appointed unopposed as the PMHA Deputy Chair for the term of the Agreement.

The Meeting accorded a vote of thanks to the AMA.

Resolved (unanimous)

That the Private Mental Health Alliance (PMHA) extends its sincere appreciation to the Federal AMA for assisting with the execution of the AMA Agreement for Services 2013–15, the review of governance arrangements for the Private Mental

Health Consumer Carer Network (Network), and the preparation of letters of offer for staff and office bearers of the PMHA, its Centralised Data Management Service and the Network. Specifically the PMHA would like to thank:

Mr Warwick Hough	*AMA Operations Manager*
Mr Howard Pickrell	*AMA General Manager Corporate Services*
Mr John Alati	*AMA Senior Industrial and Legal Officer*
Ms Marlene Shepherd	*HR Manager, Australasian Medical Publishing Company*

3.2 PMHA Work Plan 2013–15

The Meeting noted that the PMHA Work Plan 2013–15 only recently commenced on 1 July 2013. The original Plan has now been amended to include the scoping project on recognising and responding to deterioration in a person's mental state.

3.2.1 Scoping project on recognising and responding to deterioration in a person's mental state.

Since the last PMHA meeting, the Australian Commission on Safety and Quality in Health Care (ACSQHC or Commission) engaged Craze Lateral Solutions (CLS), to prepare a scoping report about recognising and responding to deterioration in a person's mental state in acute health facilities. Joining CLS in this project are:

- Douglas Holmes, a consultant with lived experience of mental illness
- Eileen McDonald, a mental health carer/family consultant
- PMHA represented by Phillip Taylor and Allen Morris–Yates
- St Vincent's Hospital's Alcohol, Drug and Mental Health Program (Sydney), represented by Dr Peter McGeorge, Steve Bernardi and Douglas Holmes

The report's purpose is to inform the Commission about what is known about this topic, gaps that could be addressed by the Commission, and whether and how the Commission's existing framework for recognising and responding to physiological deterioration could be applied to deterioration in a person's mental condition. The Project's scope, while recognising that a significant proportion of care for people mental illness is delivered in the community, will be focused on people whilst they are being treated in an acute setting, including public and private general and specialist mental health hospitals. The review's scope includes:

- Patients treated in the emergency department, those admitted voluntarily, and involuntary admissions
- All patients, not only those with a mental health admission or in a mental health inpatient facility, but also those whose mental state deteriorates whilst they are in a medical or surgical setting in a general hospital.

The Project will focus on key adverse outcomes associated with deterioration in a patient's mental state including those of:

- Suicide
- Self–harm
- Aggression to other patients, visitors and staff
- Self–discharge from acute facilities
- The need for involuntary admission and/or readmission, seclusion and restraint.

Key Questions

With respect to patients who are being treated in an acute setting, including public and private general and specialist mental health hospitals the Commission wants to know.

1. How is deterioration in a patient's mental state currently defined and assessed?

2. What are the factors, either individual or systemic, that lead to adverse outcomes associated with this deterioration?

3. How often are there adverse outcomes associated with deterioration in a patient's mental state? Where are these outcomes currently reported? Are they publicly reported?

4. What kind of strategies, tools, frameworks, guidelines and approaches are in place to support early recognition of deterioration in mental state for patients in acute care facilities?

5. What kind of strategies, tools, frameworks, guidelines and approaches are in place to manage the potential for adverse outcomes associated with deterioration in a patient's mental state?

6. How are these strategies evaluated? How successful have these strategies been?

7. What are the gaps that need to be addressed to reduce the risk of adverse outcomes associated with deterioration in a patient's mental state?

8. To what extent can the framework developed by the Commission regarding recognising and responding to physiological deterioration be applied to deterioration in a patient's mental state?

9. What actions may be needed for the Commission to contribute to improvements in this area?

To date, an online literature review and an online survey have been completed and interviews have been conducted with people working in the field to elicit what is actually happening on the ground.

The Meeting noted that Mr Taylor and Mr Morris–Yates had conducted telephone interviews with a sample of six private psychiatric facilities and the members of the AMA Psychiatrists Group and provided a summary of those interviews to CLS. Dr Craze, Douglas Holmes and Eileen McDonald are handling the other interviews, including those with private and public sector mental health consumers and carers.

Mr Morris–Yates and Mr Taylor will attend a Team Meeting on Monday, 8 July 2013 in Sydney, which will include representatives from ACSQHC.

It is anticipated that the project will now be completed before the end of 2013.

The Meeting noted that, under a contract between the AMA and Craze Lateral Solutions, Mr Taylor was devoting 0.6 days per week for 13 weeks to the Project at a cost of $9,360 (GST Exclusive) and Mr Morris–Yates was devoting 0.4 days per week for 13 weeks to the project at a cost of $6,240 (GST Exclusive). Payments will made to the AMA and held in a separate cost centre until the project is completed. The AMA will then allocate any funds remaining at the end of the project into the budgets of the PMHA and CDMS respectively, for this financial year.

4. AMA FINANCIAL STATEMENTS

The Meeting discussed the *Statements of Income and Expenditure* for the PMHA, its CDMS, the Network and the PMHA Quality Improvement Project, for the period 1 July 2012 to 30 April 2013, prepared by the AMA. The AMA has advised that the final surpluses in the PMHA, CDMS and Network budgets at 30 June 2013 will not be known until after the end of July. As requested by the Parties to the *AMA Agreement for Services 2011–13*, those surpluses will be carried forward by the AMA into the respective income streams of the PMHA, its CDMS and Network for this Financial Year 2013–14.

Resolved (unanimous)

1. *That the PMHA adopts the AMA Statement of Income and Expenditure for the Private Mental Health Alliance, its Centralised Data Management Service, and the Private Mental Health Consumer Carer Network (Australia), for the period 1 July 2012 to 30 April 2013.*

2. *That the PMHA adopts the AMA Statement of Income and Expenditure for the PMHA Quality Improvement Project (QIP).*

5 PMHA COLLABORATIVE CARE MODELS WORKING GROUP REPORT

The Chair of the PMHA's Collaborative Care Models Working Group (CCMWG), Mr Taylor, reported developments with the *PMHA's Principles for Collaboration, Communication and Cooperation between Private Mental Health Service Providers* has been completed. At the end of 2012 the Principles were forwarded for comment to the following organisations, who are involved in education, training and setting standards for the relevant professions.

- RANZCP
- RACGP
- APS
- ACMHN
- AASW
- OTA
- Mental Health Professionals Association

The CCMWG met on 12 April 2013 to discuss the comments received. The outcome of those discussions was agreement that there was sufficient consensus to indicate that the Principles are not at odds with current education and training standards, or the existing policies or procedures of these organisations. The CCMWG, agreed that the Principles would be a very useful tool for initiating discussions around referral and communication practices both toward the end of a mental health professional's training and after they have entered private practice.

CCMWG will meet on 19 July 2013 to discuss the advice of the organisations listed above concerning dissemination and implementation strategies for the Principles. Beyond that, the CCMWG will be developing a work plan, which will include the review of the 2012 Edition of the *Guidelines for Determining Benefits for Health Insurance Benefits Purposes for Private Mental Health Care*. Care will need to be exercised to ensure that all CCMWG stakeholders are involved in the development of the work plan and are happy with its content.

Ms McMahon then discussed with the PMHA whether the work plan could include a role for the CCMWG beyond an iterative process for the proposed consortium–based carer project for the development of guidelines for working with carers of people with a mental illness. Using the CCMWG as a guidelines development committee for the project would reduce the funding being sought. Most of the organisations to be represented on the Guidelines Development Committee are already represented on the CCMWG. Under this proposal, the Network would be responsible for managing the project and the project officer will be responsible for developing the guidelines in close consultation with CCMWG.

After discussion, PMHA agreed that there were no objections to Ms McMahon raising this proposal with the CCMWG at its 19 July 2013 meeting.

6. PMHA QUALITY IMPROVEMENT PROJECT FINAL REPORT

At the beginning of this Agenda Item, the PMHA Chair welcomed two invited guests, Mr Frank Quinlan, the Chief Executive Officer of the Mental Health Council of Australia (MHCA) and Mr Josh Fear MHCA, Director of Policy and Projects. Mr Quinlan and Mr Fear had accepted an invitation from the Chair to attend for discussion of Agenda Items 6, 7 and 8.

For the benefit of Mr Quinlan and Mr Fear, Mr Taylor provided a very brief overview of the PMHA's QIP as summarized below.

In 2009, an anonymous offer of financial support of $250,000 was made available to the AMA to manage, on behalf of the PMHA, for a Quality Improvement Project (QIP) directed at improving outcomes for consumers within the context of the mental health services that are provided by private Hospitals and psychiatrists in private practice. The purpose was to make better use of the mechanism of the PMHA and its CDMS.

QIP contained a suite of four complementary activities which were undertaken within the context of the available funding.

1. Implementation of a Patient Experiences of Care Measure

2. Outcomes in Private Psychiatry Practice
3. Borderline Personality Disorder
4. Internet Access to the PMHA's CDMS

In 2010, Work Programs for each of these activities were developed and the PMHA established a QIP Steering Committee (QIPSC or Steering Committee) to act as a reference group and to assist with managing the Project over the course of 2011 and 2012. QIP formally commenced at the beginning of 2011, with the appointment of the PMHA Senior Research Officer, Ms Ellie Rosenfeld. At the beginning of QIP, the Commonwealth provided $230,081 in additional funding that strengthen the Work Programs.

The QIP was largely completed by March 2013 with Ms Rosenfeld employment extended to the end of May 2013 to finish off a few outstanding matters. The Seventh and final meeting of the QIPSC was held in Canberra back–to–back with the 8 March meeting of PMHA to formally conclude the QIP.

The Meeting then considered and adopted the copy of the report of the final QIPSC meeting, noting that all resultant ongoing work has now been incorporated successfully into the normal program of work for the PMHA's CDMS (refer to Agenda Item 7 below).

Resolved (unanimous)

1. *That the Private Mental Health Alliance (PMHA) adopts the Report of the Seventh and final Meeting of the PMHA's Quality Improvement Project (QIP) Steering Committee held on 7 March 2013 in Canberra.*

2. *That the PMHA notes that the ongoing work arising from the QIP has been incorporated into the normal program of work for the PMHA's CDMS has.*

7 PMHA CENTRALISED DATA MANAGEMENT SERVICE REPORT

For the benefit of Mr Quinlan and Mr Fear, the PMHA CDMS Director, Mr Morris–Yates, provided the report on CDMS activity in the form of a comprehensive presentation that included the history of the CDMS, and some further detail on tasks that were undertaken as part of the PMHA's QIP. A brief summary of Mr Morris–Yates presentation is set out below.

7.1 Presentation for the MHCA

The PMHA's CDMS was originally established in 2001 by the AMA to support the ongoing implementation of a *National Model for the Collection and Analysis of a Minimum Data Set with Outcome Measures for Private Hospital–based Psychiatric Services*, (National Model), which was first published in May 2001 after several years of development that started in 1998. The National Model has now been implemented by all established private hospitals with psychiatric beds across Australia as listed below.

Australian private facilities with psychiatric beds participating in the PMHA's CDMS

Queensland

1. Belmont Private Hospital *****
2. Brisbane Private Hospital
3. The Cairns Clinic
4. Greenslopes Private Hospital *****
5. Hillcrest Rockhampton Private
6. New Farm Clinic *****
7. The Palm Beach Currumbin
8. Pine Rivers Private Hospital
9. St Andrews Private Hospital
10. The Sunshine Coast Private
11. Toowong Private Hospital *****

New South Wales

12. Albury Wodonga Private
13. Brisbane Waters Private
14. Baringa Private Hospital
15. Campbelltown Private
16. Dudley Private Hospital
17. Lingard Private Hospital
18. Mayo Private Hospital
19. Mosman Private Hospital
20. The Hills Private Hospital
21. The Northside Clinic
22. Northside Cremorne Clinic
23. Northside West Clinic
24. St John of God Hospital
25. St John of God Hospital
26. South Pacific Private
27. St Vincent's Private Hospital
28. The Sydney Clinic
29. Sydney South West Private
30. Warners Bay Private Hospital
31. Wesley Private Hospital
32. Wesley Private Hospital

***** Licensed to take involuntary

Australian Capital Territory

33. Calvary Private Hospital

Victoria

34. The Albert Road Clinic
35. Beleura Private Hospital
36. Delmont Private Hospital
37. Essendon Private Hospital
38. The Geelong Clinic
39. The Melbourne Clinic
40. Malvern Private Hospital
41. Mitcham Private Hospital
42. Northpark Private Hospital
43. St John of God Hospital
44. St John of God Pinelodge
45. The Victoria Clinic

South Australia

46. The Adelaide Clinic
47. Fullarton Private Hospital
48. Kahlyn Day Centre

Western Australia

49. Abbotsford Private Hospital
50. Hollywood Private Hospital
51. Joondalup Health Campus
52. The Marian Centre
53. Perth Clinic
54. Sentiens Clinic

Tasmania

55. The Hobart Clinic
56. St Helens Private Hospital
57. North West Private

Under the National Model, these participating Hospitals collect two measures of a patient's clinical status at key occasions during the provision of care. Those occasions are:

- at Admission and Discharge from episodes of Overnight inpatient care;
- at Admission and Discharge from episodes of Ambulatory care, for example Day Programs; and
- where episodes of care are extended over longer periods, at Review every three months.

The two measures of clinical status are:

- a twelve item clinician–completed rating scale, developed by the Royal College of Psychiatrists in the UK and known as the Health of the Nation Outcome Scale, or the **HoNOS**; and
- a fourteen item patient–completed questionnaire, which for our convenience is known as the **MHQ–14**.

This clinical data is recorded and then linked with data collected under the Hospital Casemix Protocol (HCP) using the CDMS's Hospitals Standardised Measures database (HSMdb), which is provided to participating Hospitals by the CDMS. The two sets of linked data are then submitted, in a de–identified format, to the CDMS by participating Hospitals. The data submitted by all Hospitals forms the basis for the Standard Quarterly Reports that are prepared and distributed to Hospitals and private health insurers by the CDMS. As well as providing participating Hospitals with a database application, the CDMS provides detailed training materials and considerable active support in the implementation of the data collection process.

Hospitals, therefore, have a more comprehensive and clinically accessible method, of describing the severity and complexity of the problems treated and a common language for discussing and comparing the outcomes of the care they provide. Clinical review and reporting functions within HSMdb enables Hospitals to select a set of records for review and statistical analysis on the basis of a very wide range of administrative, clinical and service–related attributes.

The CDMS also produces an Annual Statistical Report (ASR) on Private Hospital–based Psychiatric Services based on data submitted by private hospitals listed above. These Reports are produced each year, as part of the PMHA's ongoing commitment toward improving the quality, reliability, and use of information on private sector mental health services. Our ASRs set out useful summary statistics that include the following.

- Number of patients admitted to private hospitals for psychiatric care.
- Demographic and diagnostic profiles of those patients.

- Comparison of patients reported mental health, social and role functioning at Admission and on Discharge against that of the general population.

- Comparisons of the demographic and diagnostic profiles to indicate that generally different groups of people are receiving mental health care in each sector.

Copies of the most recent ASR were provided to Mr Quinlan and Mr Fear.

The CDMS is, therefore, the core business of the PMHA. The PMHA's CDMS is helping the private sector and the Australian Government to answer the fundamental questions that can be asked of any health system – *who receives what services, at what cost, and with what effect*. Our data shows that on admission to hospital consumers typically have very significant problems with depression and anxiety that interfere to a marked degree with their social and role functioning. By the time of their discharge, most leave feeling recovered and much more able to cope with their mental illness in the community. In operating under the umbrella of the PMHA, consumers and carers, their treating psychiatrists, participating private hospitals and payers, are provided with assurance that the highly sensitive information managed by the CDMS is protected by an appropriate governance structure.

7.1.1 Implementation of PMHA Patient Experiences of Care Measure (PMHA–PEx)

The PMHA's CDMS is now responsible for the implementation of the PMHA–PEx developed under the auspice of the PMHA's QIP. Mr Morris–Yates explained that in developing the PMHA–PEx the agreed objective was to bring together the following three surveys that were under development.

1. PMHA's Consumer Perceptions of Care Survey (PMHA–CPoC), which was based on the MHSIP Adult Consumer and the NRI Inpatient Consumer Surveys used in the pilot study of the routine collection and reporting of consumers' perceptions of care in eight private hospitals, completed in 2006.

2. The new Consumer Experiences of Care Survey developed for use in public sector inpatient and community based mental health services (PMHS–EoC), developed by a project team within Victoria's Department of Human Services for the AHMAC National Mental Health Working Group's Mental Health Information Strategy Subcommittee.

3. The brief Patient Experiences of Care Survey being developed by the Australian Commission on Safety and Quality in Healthcare (ACSQHC–PEx).

In conducting the analysis of the above three surveys, we also reviewed and made reference to the item content of three other surveys, two specifically designed for use in mental health service settings and the other designed for use in the general hospital setting. The first was New South Wale Health's *Mental Health Consumer Perceptions and Experiences of Services* survey (MH–CoPES),[1] which was being used by public

[1] NSW Department of Health (2006) *A statewide approach to measuring and responding to consumer perceptions and experiences of adult mental health services*. A report on stage one of the development of the MH–CoPES framework and questionnaires. Sydney, NSW Health.

sector mental health services in that state.[2] The second was the originally published long version of the *Verona Service Satisfaction Scales* (VSSS–54).[3] Unfortunately, we were not able to work off the most recently published translation of that survey, the VSSS-EU, developed for use in the Epsilon 7 study and now widely used across the European Union, but instead have relied on an English translation of the original version obtained from the survey's authors in 1995.[4] The third is the 2008 version of the UK National Health Service's *Inpatient Questionnaire* (NHS–2008).[5] The content of that survey and an analysis of it reported in a discussion paper published in 2009,[6] formed the starting point for the PEx development work now being undertaken by the ACSQHC.

The final item content and the framework for analysis and reporting for both the PMHA–PEx Overnight Inpatient Care Survey and the Ambulatory Care Survey have been endorsed by the APHA–Psychiatry Committee and the National Committee of the PMHCCN. The PMHA–PEx Survey instrument together with PMHA–PEx related local analysis and reporting functionality are currently being integrated within the CDMS Hospital Standardised Measures Database (HSMdb). Implementation by Hospitals then will coincide with the release of the next version of the HSMdb in August. Hospitals will be provided with the Survey templates and a manual with suggestions about how to offer the Survey. That manual is being enhanced based on feedback from Hospitals.

Ms McMahon asked whether the data derived from the measure would be able to be made available to feed back to the PMHCCN. Morris–Yates and Ms Munro reiterated that it will be several years before Hospitals are proficient with using the PMHA–PEx and before the CDMS is confident that the interrogation and reporting of the data is robust. The HoNOS and the MHQ–14 both had a pedigree and were reasonably simple instruments to use and report on. PMHA–PEx is an entirely new instrument with a new set of items that are strongly related to critical issues for Hospitals. In addition, should any problems arise during the implementation, then the CDMS will need to adjust the instrument, and/or its reporting software.

7.1.2 Outcomes in Private Psychiatry Practice

Under the PMHA QIP, a Private Psychiatrist Research Network (PPRN) was established, comprised of 19 psychiatrists, and a Psychiatrists Workload Study (WLS) was conducted. Distribution of the WLS Final Report completed this component of the QIP.

Copies of the *Psychiatrists' Workload Survey 2012 Final Report* are available from the PMHA website at www.pmha.com.au.

---

2 Oakley, Malins and Doyle (2011) *The MH–CoPES Framework and Questionnaires ready for statewide implementation. Final Report of the MH–CoPES Stage 2 Project.* Sydney, NSW Consumer Advisory Group–Mental Health Inc.

3 Ruggeri and Daii'Agnola (1993) The development and use of the Verona Expectations for Care Scale (VECS) and the Verona Service Satisfaction Scale (VSSS) for measuring expectations and satisfaction with community–based psychiatric services in patients, relatives and professionals. Psychological Medicine, 23, S11–523.

4 Ruggeri, et al (2000) Development, internal consistency and reliability of the Verona Service Satisfaction Scale– European Version EPSILON Study 7. British Journal of Psychiatry, 177, s41–s48.

5 Garratt (2009) The key findings report for the 2008 inpatient survey. Oxford, Co–ordination Centre for the NHS Patient Survey Programme, Picker Institute Europe. Obtained from http://www.nhssurveys.org/ in April 2012.

6 Sizmur and Redding (2009) Core domains for measuring inpatients' experience of care. Oxford, Picker Institute Europe.

7.1.3 Internet Access to the PMHA's CDMS

Under the PMHA's QIP, the redevelopment of the PMHA website was completed to a point whereby the old website was replaced with the architecture necessary to eventually enable secure access for private hospitals and private health insurers to CDMS Training Resources and Standard Quarterly Reports.

An *AMA Agreement for Internet Access to the Secure Areas of the PMHA's CDMS Website*, was also drafted in consultation with the AMA. The PMHA's CDMS is now responsible for:

a) finalising the *AMA Agreement for Internet Access to the Secure Areas of the PMHA's CDMS Website* in consultation with the PMHA; and

b) testing and implementation of internet-based access to subscriber only resources and reports through the PMHA website's secure portal for private hospitals and private health insurers.

Mr Taylor and Mr Morris–Yates reported that these remaining tasks have been delayed due to work now involved their contractual participation for the PMHA in the scoping project being conducted for ACSQHC on recognising and responding to deterioration in a person's mental state (refer to Agenda Item 3.2.1 above).

7.1.4 Borderline Personality Disorder

Under the PMHA's QIP a survey about the provision of psychological services to people with diagnoses of Borderline Personality Disorder (BPD) who are admitted to private hospitals was conducted. Release of the Final Report on the BPD Survey completed this component of QIP.

Copies of *The Provision of Psychological Services for Borderline Personality Disorder in Private Hospital Settings Final Report March 2013* are available from the PMHA website at www.pmha.com.au.

7.1.5 CDMS Work Plan 2013–15

Mr Morris–Yates briefly explained that beyond the routine work of the CDMS, some of which is described above, the work program for the CDMS will now be largely focussed on the following.

- Revision and update of the HSMdb software for Hospitals. A new fully revised version of the HSMdb software built in MS Access 2010 or 2012 will be released to Hospitals after rigorous testing, both of the new version in its own right and of the data transfer process.

- Re–development of the four components of the CDMS Data Warehouse (this task was put on hold for the duration of the PMHA's two year QIP), including:

  – entity management;
  – data submission and processing;
  – analysis and reporting (Incorporation of the PMHA PEx Measure); and
  – documentation of process for alternate administrators.

The Chair thanked Mr Morris–Yates for his report and presentation.

8. PMHA COMMUNICATION

PMHA Communication is an ongoing Standing Item on the PMHA Agenda for discussion of issues related to the PMHA Newsletter and what other strategies might be used to promote the private sector.

Under this Agenda Item, a range of issues were discussed with Mr Quinlan and Mr Fear as summarised below.

8.1 Activity Based Funding for Mental Health

The PMHA has provided a submission to the University of Queensland (UQ) on its *Stage B Consultation Paper: A Recommended Framework for Classification Development for Classification Development Definition and Cost Drivers for Mental Health Services project*, prepared by UQ for the Independent Hospital Pricing Authority (IHPA) to assist the development and specification of a mental health classification system.

In its submission, the PMHA's major concern is that regardless of the fact that IHPA may see its work as only applying to the public sector, any such classification and its associated funding model will have a direct impact on private hospitals, if not immediately then certainly within three to five years of its implementation in the public sector. Such a pricing structure and funding model may not be at all appropriate for the private sector given the differences in casemix and models of service delivery. It is therefore critical that the private sector is involved in the classification development.

8.2 Scoping project on recognising and responding to deterioration in a person's mental state.

Mr Taylor provided a brief overview of the PMHA's involvement in the scoping report about recognising and responding to deterioration in a person's mental state in acute health facilities, as detailed under Agenda Item 3.2.1 above.

8.3 MHCA

The Chair then invited Mr Quinlan and Mr Fear to report on and discuss MHCA activities. A summary of that discussion appears below.

8.3.1 Governance

MHCA is at the end of its three year strategic plan and moving to a better constitution, which will see the MHCA transition to a company limited by guarantee. To do this, the new constitution is being developed in line with the Corporations Act and will need to be endorsed by at least 75% of the members at the 9 October 2013 MHCA Annual General Meeting. Ms Jennifer Westacott recently replaced the Hon Rob Knowles as Chair of the MHCA.

8.3.2 Lobbying

Recent events in Canberra have seen the appointment of a new Minister for Mental Health and Ageing, Senator the Hon Jacinta Collins, who replaces The Hon Mark Butler. Minister Collins comes with a background in social work and welfare and a long period of service as a Victorian Senator. Mr Quinlan and Mr Fear have met with the new Minister, and MHCA staff have been assisting her office with the transition as there is a lot to absorb in a short time. MHCA will be working closely with Minister Collins and her staff in the lead up to the Federal Election. Staff from Minister Butler's office, including Mr David McCann, are also working with Minister Collins to ensure continuity. MHCA remains, however, non–partisan in its politics and has engaged directly with the Shadow Minister, Senator Concetta Fierravanti–Wells as the Coalition prepares its position ahead of the forthcoming election. Senator Fierravanti–Wells has also been touring the county carefully gathering input from various parts of the sector.

8.3.3 National Indicators and Targets for Mental Health Reform

In partnership with the National Mental Health Commission (NMHC), the MHCA recently convened consultations with the non–government mental health sector on National Indicators and Targets for Mental Health Reform. The consultations will inform the deliberations of the Expert Reference Group (ERG) established by COAG to provide expert advice to governments on a set of aspirational and achievable national outcome indicators and targets for mental health that will drive transformational change and be understood by the community. Mr Quinlan is on the ERG as the Commonwealth's nominee.

The MHCA has reported to the NMHC on the findings of its consultations with the National Mental Health Consumer Carer Forum (NMHCCF), the National Mental Health Consumer and Carer Register, and the Council of Non Government Organisations on Mental Health (CONGO).

Informed by the MHCA's consultations, but also by its own consultations, the ERG recently circulated a draft framework of targets and indicators to a range of organisations for comment, including PMHA. Mr Fear explained some of the thinking which has led to the selection of certain targets and indicators in the draft framework. The ERG believes that a small number of whole of life targets has the best potential to set a clear destination for Australia, and drive change. The ERG will be making recommendations to the Ministerial Working Group on the targets and indicators to be included in Councils of Australian Governments (COAGs) 10 year Road Map for Mental Health Reform. PMHA noted there is no private sector representation on the ERG.

Mr Fear mentioned that the framework represents a move away from episodes of care to a whole of life focus that will require data collections to support that focus. Ms Carol Turnbull felt that the HoNOS should not be overlooked because it does include a whole of life focus. Mr Morris–Yates indicated that this was also the reason HoNOS is used by the CDMS precisely because of its inclusion of social and role function. It is social and role function deficits that cause people to enter into care rather than just the severity of their symptoms.

Mr Fear confirmed that the development of these targets and indicators deliberately ignored all the work that has been done on targets and indicators in mental health in order to begin again and build a set of targets and indicators based on feedback from consumers and carers. The AHIW is now going through a process of scanning all the existing sources of indicators to determine which ones might meet this ambition. The private sector collection should be captured as part of that process.

8.3.4 National Disability Insurance Scheme

For some years the MHCA has been also actively involved with the design of the National Disability Insurance Scheme (NDIS), and has recently been funded by FaHCSIA to help build the capacity of the mental health sector to engage with DisabilityCare Australia (DCA).

MHCA was one of the advocates who lobbied to have psychosocial disability caused by mental illness covered by the NDIS. There remain however a vast amount of questions around who is and who is not eligible for support of different kinds through DCA, and how the needs of people who are not eligible for full support will be met and through which service systems. Those questions will be resolved one way or the other as the NDIS roll out continues.

One of the MHCA's major concerns at present is bilateral agreements that the Commonwealth and each State and Territory have entered into that define which services are considered to be in the NDIS and those that are not. In scope services are either cashed out programs, whereby the program is shut down and the cash remaining is transferred in the NDIS. Services considered to be in kind, which means the program will continue but for accounting purposes will be counted as part of the NDIS. Given we know the financial pressures governments are under to meet the enormous financial contributions that are required to support the NDIS a lot of programs are in. There is some visibility at the national level but not at the state level as yet as to what services for people with psychosocial disability are now considered wholly or partly in scope for the NDIS. At the Commonwealth level this means that programs such as the Partners in Recovery Program and the Personal Helpers and Mentors Program are considered in scope. However, those people who are not captured by the NDIS will have no access to these programs. There is a worrying possibility that the financial pressures on the NDIS will lead to a broad lack of services outside the NDIS, along with a gap between the quality of services delivered through or beyond the NDIS.

8.3.5 Partners in Recovery Program

MHCA takes an ongoing interest in the continued rollout of the Partners in Recovery Program. The MHCA's recent discussions suggest little to report at a national level, but a great deal of work, and variation, at the local level.

8.3.6 Activity Based Funding for Mental Health

MHCA is also involved in discussions around Activity Based Funding for Mental Health and has met with Independent Hospital Pricing Authority (IHPA) to discuss progress and the particular challenges in both clinical mental health and community mental health. The risk is that the emphasis in mental health will shift back to hospitals,

because community mental health has not been good at counting and describing what it does.

8.3.7 Mental Health Nurse Incentive Program

The MHCA is on a working group looking at the redevelopment of the Mental Health Nurse Incentive Program in the hope that funding measures in future budgets will address some of the particular issues that the MHNIP addressed. Evaluation of MHIP demonstrated while it was good program, both the geographic and demographic distribution of that program were grossly uneven across the country.

8.3.8 Discrimination in Insurance Project

MHCA is also involved with the issue of Discrimination in Insurance Project. The MHCA commenced the project in partnership with beyondblue. We have now been joined by the Public Interest Advocacy Centre and Herbert Smith Freehills who are offering their pro–bono support for the project. We hope this powerful partnership will ultimately see those affected by mental illness able to access the same range of insurance products that are enjoyed by the rest of the community at a price that is fair and reasonable.

8.3.9 Future Work

Future strategic work for the MHCA will include advocating further investment in early intervention, prevention and promotion in mental health and the peer workforce. Australia is the only OECD nation that does not have a national mental health promotion and early intervention strategy. The primary focus of the Australian National Preventive Health Agency (Promoting a Healthy Australia) is on the prevention of overweight and obesity, tobacco control, and harmful alcohol use. It ignores promotion, prevention and early intervention in mental health.

In discussion, Dr Yong mentioned that a national framework for mental health promotion, prevention and early intervention must include early childhood. Australia lags behind other countries in this area. Dr Yong recommended MHCA working with groups like Early Childhood Intervention Australia (ECIA) that are able to advocate across sectors. Mr Quinlan indicated capacity to advocate across sectors was one of the primary reasons for the MHCA and the National Mental Health Commission establishing the CONGO. CONGO brings together senior representatives from leading organisations across the mental health, employment, housing and social welfare sectors to discuss how Australia's non–government organisations can foster a better integrated, better coordinated response to mental health.

8.3.10 Private Sector representation on the MHCA

Private sector representation on the MHCA was discussed. Mr Taylor clarified that, at present, representation is limited to PMHCCN and Ramsay Health. After discussion, Mr Quinlan suggested that the PMHA consider formerly applying for full membership of the MHCA. Mr Quinlan felt the application would be positively received. Mr Quinlan also offered to attend future meetings of the PMHA to strengthen the linkage between the two organisations.

The Chair thanked Mr Quinlan and Mr Fear for attending the meeting.

8.4 PMHA Newsletter

Mr Taylor reported that the Fourteenth Edition of the PMHA Newsletter was released in April 2013.

The Meeting then considered the next Edition of the Newsletter and made several suggestions, including an article on the CDMS data now being provided to the Australian Institute of Health and Welfare (AIHW) for the National Mental Health Report.

It was left in the hands of the PMHA Director to develop the Newsletter for approval and circulation out–of–session.

Resolved (unanimous)

That the Private Mental Health Alliance (PMHA) requests that the necessary steps be taken to develop the Fifteenth Edition of the PMHA Newsletter for review and approval out–of–session by PMHA, prior to its release.

Action: PMHA Director/PMHA

9. PRIVATE MENTAL HEALTH CONSUMER CARER NETWORK (AUSTRALIA)

The Meeting noted the report of the Network's National Committee (NC) meeting held on 25/26 February 2013 in Melbourne.

The next meeting of the NC will be held at RANZCP Headquarters in Melbourne on 26/27 August 2013.

Ms McMahon reported on the following Network activities.

9.1 Project Brief for Australian Guidelines for Working with Carers of People with a Mental Illness

The PMHA has endorsed the Chair of the Network proceeding with negotiations to fund a consortium–based project for working with carer of people with a mental illness, subject to review of the project brief and inclusion of an iterative process between the consortium's project and the PMHA's CCMWG. Since the last meeting of the PMHA, the project brief underwent review to include:

- the development of common core principles on what might be considered best practice for working with carers of people with a mental illness, might be a more appropriate and achievable charter for the consortium's project; and
- a supportive and iterative process between the consortium's project and the PMHA's CCMWG.

A consortium of the organisations would be involved with the Network as the lead agency. Mental Health Carers ARAFMI WA Inc. is willing to undertake the necessary contractual agreements for the project and to hold and administer the project funding. Discussions are underway concerning funding for the project.

9.2 Network Coordinators

The selection process is underway to fill the vacant position for the Network's Coordinator for South Australian. The Selection Panel includes the Network Chair and Deputy Chairs, and the Independent Chair of the PMHA.

9.3 Projects Reviews and conferences

Network has also been involved in the following.

- Scoping study on the implementation of the *National Safety and Quality Health Service Standards* (NSQHS) and the *National Standards for Mental Health Services* (NSMHS) being conducted by ACSQHC and the NMHC.
- Scoping project for ACSQHC on recognising and responding to deterioration in a person's mental state described under Agenda Item 3.2.1 above.
- Contributing Life Project being conducted for the National Mental Health Commission.
- RANZCP Post Traumatic Stress Disorder (PTSD) Review.
- The Network will have a booth at The Mental Health Services Conference (TheMHS to be held in Melbourne between 20 and 23 August 2013.

9.4 Borderline Personality Disorder (BPD)

The Australian BPD Foundation has invited Ms McMahon to become a patron for the Foundation. Ms McMahon would like to take up this position in her own right as a private citizen. After discussion, PMHA agreed that there was no objection to Ms McMahon taking up this position.

As Members of the BPD Expert Reference Group, Ms McMahon and Professor Louise Newman are seeking appointments with both the new Minister for Mental Health and Ageing, Senator the Hon Jacinta Collins, and the Shadow Minister, Senator Fierravanti–Wells to discuss consumer and carer issues around BPD.

After discussion, PMHA asked Ms McMahon to firstly ensure that the members of the Network's National Committee were supportive of these approaches. The PMHA felt caution should be exercised with these additional endeavours, given both the workload involved with the full time role of Network Chair. There is also a need to ensure there is no conflict of interest between this work and the Network's role in representing all private sector consumers and carers irrespective of their particular mental illness. The PMHA Chair agreed to give this matter some further thought and provide advice for Ms McMahon out–of–session.

9.5 Representation and appointments

Mr Hardwick continues to represent the Network on the National Mental health Consumer Carer Forum (NMHCCF or Forum) and was recently appointed to Forum working group looking at forming partnerships and alliances. Mr Hardwick has also been reappointed to the Expert Reference Group for the Mental Health Nurse Incentive Program and recently attended the final meeting of the Consumer and Care Reference Group for National Mental Health Service Planning Framework (refer to Agenda Item 11 below).

Ms McMahon and Mr Hardwick attended the NMHCCF and National Register of Mental Health Consumer and Carers Workshop, which had some focus on the development of a consumer and carer peer workforce.

Mr Patrick Hardwick and Mr Norm Wotherspoon have been put forward as consumer and carer candidates for the National Peer Worker Qualification Reference Group, which will inform the development of national learning and assessment resources for the Certificate IV in Mental Health Peer Work.

Mr Hardwick attended the joint National Mental Health Commission and MHCA Workshop on the development of National Indicators and Targets for Mental Health Reform.

Mr Hardwick also represents the NMHCCF on the ACSQHC Advisory Group for the scoping study on the implementation of the *National Safety and Quality Health Service Standards* (NSQHS) and the *National Standards for Mental Health Services* (NSMHS).

At the end of this Agenda Item, Ms McMahon mentioned that meetings attended each month is now being included in the Network's monthly e–News Alert for Network Members and Friends.

10 MENTAL HEALTH DRUG AND ALCOHOL PRINCIPLE COMMITTEE

In 2012, a review of Australian Health Ministers Advisory Council (AHMAC) committee and governance structures resulted in the work of the Mental Health Standing Committee (MHSC) being subsumed under the auspice of the new Mental Health/Drug and Alcohol Principal Committee (MHDAPC) of AHMAC. MHDAPC is only comprised of Senior Government Officials. The role of the MHDAPC is to advise AHMAC on national mental health, alcohol, tobacco, and other drug issues. This work is being undertaken in a complex environment which includes oversight of the Fourth National Mental Health Plan, the National Drug Strategy, the mental health, drug and alcohol elements of the Closing the Gap initiative for Indigenous People and implementation of designated COAG Mental Health reform initiatives.

The PMHA is linked to the work of the MHDAPC through the positions it holds on MHDAPC's Mental Health Information Strategy Standing Committee (MHISSC) and its Safety and Quality Partnership Standing Committee (SQPSC). The PMHA is represented on the MHISSC by the PMHA Deputy Chair, Ms Moira Munro and on the SQPS by Dr Bill Pring.

The PMHA noted that MHDAPC has a new Chair, Mr Jeff Moffet, CEO Northern Territory Department of Health who commenced in April 2013. MHDAPC last met on 6 June 2013. Items on the agenda included:

- Review of the Fourth National Mental Health Plan
- Public release of National and State/Territory seclusion and restraint data
- In relation to the review of the Fourth National Mental Health Plan a project steering committee is being established to project oversight to the review which will be undertaken in the latter part of 2013. The Working Group on Mental Health reform will utilise the outcomes of the review in its work to develop a successor to the Fourth Plan.
- The public release of National and State/Territory seclusion and restraint data is a matter that was referred to the MHDAPC from the SQPSC. The matter has been discussed at AHMAC CEOs meeting and is to be discussed at the SCoH teleconference to be held on 26 July 2013.
- A number of matters have been progressed by the MHDAPC out–of–session including the following matters from the SQPSC.
    - Mental Health Professional Online Development (MHPOD) Further Development Services
    - National Practice Standards for the Mental Health Workforce, and the
    - National Recovery Framework
- Other matters progressed out–of–session include the following.
    - Review of the draft Implementation Plan for the National Mental Health Workforce Strategy and Plan (NMHWSP)
    - Endorsement of the National Mental Health Report, from MHISSC.
    - Endorsement of the 5th COAG National Action Plan on Mental Health Plan Progress Report, from MHISSC.

The PMHA noted the next meeting of the MHDAPC will be held on 28 August 2013.

10.1 MHDAPC: SQPSC Report

The SQPSC is responsible for taking the Australian Government mental health safety and quality agenda forward, which involves working closely with ACSQHC.

The Meeting noted a copy of the minutes of the SQPSC meeting held on, 15 March 2013 in Sydney and a copy of the draft agenda for the meeting of the SQPSC to be held on 12 July 2013 in Melbourne.

A summary of key developments and SQPSC activities is set out below based on the report provided by Dr Pring, information extracted from on SQPSC reports, and additional information provided by Ms Helen Marx.

10.1.1 Mental health workforce safety and quality elements

MHDAPC has given SQPSC the responsibility for the Mental Health Professional Online Development (MHPOD) project and the National Practice Standards following the cessation of the Mental Health Workforce Advisory Committee in January 2013. A review of the MHPOD Project Steering Committee will be undertaken with the intention of forming a workforce subcommittee under SQPSC to oversight this work however, the contractual arrangements will continue to sit with Victoria. SQPSC is currently considering the out–of–session endorsement of the Practice Standards. Ms Turnbull reported that MHPOD is proving to be an excellent online leaning tool.

10.1.2 Recovery Oriented Care

The National Recovery Oriented Mental Health Practice Framework and accompanying Policy and Theory document have been completed, along with guides for Practitioners and Consumers and Carers. A national implementation strategy and a communication strategy are currently being drafted. SQPSC anticipates the Framework and accompanying implementation documentation will be progressed to Health Ministers in time for a formal launch at the MHS Conference in August 2013. Jurisdictions will then be responsible for local promotion and dissemination of the Framework. Hard copies of the Framework document and the guides will be available from August/September 2013.

10.1.3 Mental Health Statement of Rights and Responsibilities

This document has been revised and electronic copies are available on line via the DoHA and MHSC website. Hard copies are being distributed to jurisdictions and stakeholders. Jurisdictions will be responsible for local communication and education strategies and quality improvement processes.

10.1.4 Reducing adverse medication events (RAME)

Professor Mark Oakley Browne is now the new Chair of the RAME working group due to the departure of Dr Rowan Davidson from the Chief Psychiatrist role in Western Australia. Several teleconferences to progress the priority areas have been held with the following outcomes.

- ACSQHC has circulated their Clozapine titration chart for information and use by all jurisdictions. The Commission has also invited SQPSC to participate in its medication safety program.

- Investigations have been made regarding the development of a national database to record relevant data and information in the areas of deaths and serious adverse medication events in relation to psychotropic medications and associated physical health outcomes.

- A contained literature review to examine critical areas or "hot spot" areas with antidepressant use in the child/youth population has been finalised by the WA Health Department and will be considered by SQPSC at its next meeting in July.

10.1.5 Recognition and response to clinical deterioration

ACSQHC has undertaken a scoping study focusing on recognising and responding to deterioration in mental state for inpatients in acute health facilities, as detailed under Agenda Item 3.2.1 above. A select tender process was undertaken with the successful tenderer being Dr Leanne Craze. The project is currently in progress. The results of the project will be feedback at the November 2013 SQPSC meeting.

10.1.6 National Standards for Mental Health Services

Activity in relation to the National Standards for Mental Health Services are focussed on the following.

Consultation Draft Accreditation Workbook

ACSQHC, in collaboration with the DoHA and SQPSC, have developed a Consultation Draft Accreditation Workbook (Workbook) to assist mental health services to understand and to determine if they meet the requirements of the *National Safety and Quality Health Service Standards* (NSQHS) and the *National Standards for Mental Health Services* (NSMHS). The Workbook was released on the ACSQHC website in December 2012 with a consultation survey conducted between 18 December 2012 to 15 April 2013. The results of the consultation are currently being collated and analysed. A stakeholder workshop is being considered following a review of the survey outcomes. The workshop will consider further feedback on the usefulness of the workbook and inform revisions of the final document prior to publishing online.

Scoping Study on the Implementation of National Standards in Mental Health Services

ACSQHC in collaboration with the National Mental Health Commission, is conducting a study on the implementation of both sets of standards in mental health services in the public, private and community managed sectors. The national online survey was conducted from 29 April to 3 June and the results of the survey are currently being analysed. The results of the survey will inform the focus of a national round of focus group to be conducted from July to September in all States and Territories. These are designed to gather local knowledge about implementation of the standards, to strengthen and understand the data collected in the survey. The focus groups will include groups with people with lived experience of mental health issues and their support people, as well as with service providers. Invitations to participate have been circulated through key stakeholder networks, websites and via an expression of interest at the completion of the national survey.

Tailored Standards and Performance Pathways Mental Health Portal Pilot Project

After the NSMHS were launched in September 2010, a number of fora were held throughout 2011 to explore the accreditation, monitoring and reporting issues against the Standards. Issues of accreditation against the Standards raised by the Non–government organisation (NGO) sector are the limited resources typical of this sector

and the importance of trying not to create an additional administrative burden and avoiding duplication with existing standards.

To assist with addressing these issues, DoHA in partnership with the Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA) is piloting a tailored online self–assessment tool called the Standards and Performance Pathways mental health portal ('Portal'). The main aim of the project is to provide a tool to assist NGO services to prepare for accreditation against the standards. It will also pilot a system to report on accreditation in the NGO sector, promote and encourage the uptake of the Standards by NGOs and streamline the process by avoiding duplication with existing standards.

The Community Mental Health Australia (CMHA) has agreed to partner with the Commonwealth by hosting the link to the portal on the CMHA website, promoting and championing the portal to the NGO sector, assessing Expressions of Interest from interested organisations to ensure they have reached the preparatory stage for accreditation against the Standards before being encouraged to register on the portal and by participating in the development of an evaluation process with the Commonwealth of the uptake of, and user feedback on, the portal. A Steering Committee with representatives from DoHA, FaHCSIA and CMHA has been established and has met to discuss the features of the tailored Portal. The Steering Committee will provide SQPSC with updates on progress at its scheduled face–to–face meetings. It is anticipated that the Portal will be available and fully functional on the CMHA website (www.chma.org.au) at the end of July 2013.

10.1.7 Physical Health

Professor Tim Lambert of the Concord Centre for Cardiometabolic Health in Psychosis gave a presentation on possible approaches to developing national guidelines on physical and metabolic health for mental health clinicians with reference to the use of antipsychotic medication. Subsequently, the NSW Minister for Mental Health, Kevin Humphries and the Commonwealth Minister for Mental Health and Ageing, Mark Butler, co–hosted a Summit on physical health in Sydney on 24 May 2013, which was attended by ministers and senior representatives from across Australia.

10.1.8 Seclusion and Restraint Reduction in Mental Health Services

Following the completion of the National Beacon Project states and territories have continued to maintain a focus on seclusion and restraint reduction and support for annual national seclusion and restraint forums.

For the 2011–12 national forums jurisdictions collaborated, via the SQPSC Chief Psychiatrist/jurisdictional members, in bringing together national performance data on current rates of seclusion for presentation to the Forums. These ad hoc collections were supported by MHISSC and the AIHW assisting with the validation and analysis of the material. The intention is to continue this collaborative process on an ad hoc basis until more formal annual national data reporting is available.

A working group was formed in 2012 to progress the work in relation to reducing restraint in mental health services, an area not well addressed during the Beacon Site Project. A jurisdictional stocktake of restraint activity, data collection, governance

structures and workforce and education standards was completed in July 2012. A review of jurisdictional protocols guiding the use of restraint in use in mental health services and other health services is a work has been completed and work to develop guiding principles is underway.

The ACT is hosting the 2013 forum with the date set as 28–29 November.

10.1.9 SQPSC Chair arrangements

Associate Professor John Allan was elected as Chair of SQPSC at the 15 March 2013 meeting. The nomination and election process to the now vacant Deputy Chair role will be undertaken at the July 2013 meeting.

10.2 MHDAPC: MHISS Report

MHISS provides expert technical advice and recommendations on initiatives to address the information requirements for MHDAPC.

The Meeting noted the copy of the minutes of the MHISS meeting held on 21/22 March 2013 in Adelaide and the agenda of the MHISS meeting held on 6/7 June 2013 in Perth. The PMHA Representative on the MHISS, Ms Moira Munro, attend both meetings and Mr Morris–Yates accompanied Ms Munro for the 21/22 March meeting in Adelaide. The next meeting of MHISS will be held on 17/18 October 2013 in Canberra and Ms Munro will attend.

A summary of key developments and MHISS activities is set out below is based on the report provided by Ms Munro, information extracted from on MHISSC reports, and additional information provided by Mr Morris–Yates.

10.2.1 Activity Based Funding and Mental Health

Under the National Health Reform Agreement all governments are moving to introduce Activity Based Funding (ABF) arrangements for public hospital services based on a National Efficient Price. COAG agreed to establish the Independent Hospital Pricing Authority (IHPA) as a Statutory Authority under the National Health Reform Act 2011. The role of the IHPA is to provide independent advice about the efficient cost of public hospital services by determining in–scope services, classification schemes for these services, and a national efficient price, including for mental health.

IHPA has been actively consulting on the development and scope of the Pricing Framework for Australian Public Hospitals, released in May 2012, and is aware of the strong interest of the mental health sector in contributing to the development of ABF for mental health services. IHPA has determined a need to develop a new classification for mental health for the purposes of costing and funding. While new ABF definitions, data collections, classifications and reporting mechanisms for mental health services are being developed, the Commonwealth will be undertaking the following.

(1) In 2012–13, fund public hospital mental health services in on a block funding basis.

(2) In 2013–14, fund health services on the basis of the setting in which they occur using established admitted, non–admitted and emergency department classifications and pricing.

IHPA will continue to consult with key stakeholders to ensure that the ABF model developed is appropriate for mental health services. On 25 July 2012, the Authority held the first meeting of the Mental Health Working Group, which consists of representatives from each jurisdiction and key mental health stakeholders and organisations. The Mental Health Working Group is providing guidance and oversight for the development of a new mental health classification system, pricing for mental health services and the scope of community–based services to be funded through activity based funding. The Mental Health Working Group work plan includes the development of a new Australian Mental Health Care Classification and calculating a national efficient price for mental health services.

Under the National Health Reform Act 2011, IHPA is authorised to determine the classification and coding standards that will be used for mental health services in Australia and ABF purposes. To achieve this, a nationally consistent definition of mental health services is required.

In 2012, IHPA engaged a consortium to undertake a project to define mental health services (Stage A– interim report due June 2013); and then identify the cost drivers (Stage B – report due February 2014). The consortium is led by University of Queensland (UQ) is comprised of jurisdictions (Queensland, New South Wales and Victoria).

UQ carried out a nationally inclusive consultation (Stage A) last year with key stakeholders regarding the definition of mental health services in Australia for classification purposes. A consultation paper was released that provided an overview of key issues for consideration and posed a series of focused consultation questions. All interested parties were invited to make submissions by 6 December 2012. Comments gathered during this consultation process were used by the UQ consortium to inform a report to IHPA, which contains a summary of the review of Australian and international definitions of mental health services, consultation feedback, and a recommended definition of mental health services for classification purposes. This is available to download from the IHPA website.

Also in May 2013, UQ commenced a targeted consultation on its *Stage B Consultation Paper: A Recommended Framework for Classification Development Definition and Cost Drivers for Mental Health Services project*. Stage B of the project aims to identify and analyse the cost drivers for mental health services to recommend a framework for mental health casemix classification development. The purpose of the Consultation Paper is to guide consultations with key stakeholders in relation to the program of work that will be required to develop Version 1 of the national mental health classification. As part of that process a cycle of ongoing classification development will be established and a timetable for the development of Version 2 will be agreed. The UQ targeted consultation was conducted within a limited timeframe for this early stage of the project and both MHISSC and PMHA have made submissions since the last meeting of the PMHA.

IHPA has also contracted the AHIW to undertake a review of the definition of sub acute care. A workshop was held on 28 September 2012. The Commonwealth has encouraged IHPA to also consider work already funded by the Commonwealth to develop definitions for sub acute mental health services as part of the National Mental Health Service Planning Framework.

The MHWG is considering calculation of the National Efficient Price in 2013–14. As the existing Diagnosis Related Group (DRG) structure does not adequately describe the pricing and funding needs of mental health services, it is not a good predictor of resource consumption for admitted mental health services. The IHPA is analysing available data to assess variables that could be used in addition to the DRGs to improve the accuracy of pricing calculations for admitted mental health services. Variables being considered include age, legal status, type of psychiatric unit, homelessness, location of residence and language.

Ms Munro felt it would be critical for the private sector to remain involved in the development of the IHPA casemix classification for mental health.

10.2.2 National Mental Health Report

At the April 2010 meeting, MHISSC considered and endorsed the proposed content outline for a revised National Mental Health Report (NMHR). The revised NMHR will include indicators from the current COAG Action Plan Progress Reports and Fourth Plan indicators as data becomes available. It will include updates from lead agencies on progress against actions under the five Fourth Plan priority areas. Implementation progress reporting will focus on 'national highlights' rather than jurisdictional–level analysis.

On 29 June 2012 the Commonwealth entered into a contract with the University of Melbourne to develop and draft the first revised NMHR. The Standing Council on Health endorsed the revised outline and structure for future NMHRs on 10 August 2012. This will include annual reporting on implementation of the Fourth Plan, the first of which will incorporate implementation for both 2011 and 2012.

Data has been submitted for the first time from the PMHA's CDMS to provide an accurate representation of private psychiatric hospital–based care across Australia. It is anticipated that more requests for data from the CDMS will be forthcoming, given the accuracy of the collection.

10.2.3 MHISSC National Mental Health Performance Subcommittee (NMHPSC)

NMHPS was established to oversight the development and implementation of a national performance measurement framework for mental health services to support benchmarking for mental health service improvement, and provide national information on mental health system performance. Some of the topics being progressed by the NMHPSC include the following.

<u>Third Edition of the Key Performance Indicators (KPI) for Australian Public Mental Health Services</u>

The Third Edition KPI document will be published in the later half of 2013. Mr Taylor was asked to provide copies to the PMHA, when available.

Implementing National Mental Health KPIs in Australian States and Territories – 2013 Public Report

A report on the results of the 2013 implementation survey will be uploaded to the Department of Health and Ageing website pending MHISSC feedback and endorsement. Comparisons of results of the past three surveys have identified that state and territory feedback in putting the national indicators into action has remained relatively similar. In light of there being only slight variations each year, the NMHPSC has recommended that the frequency of the implementation survey and the publication of the public report be reduced to every two years.

Average length of stay measure for Report on Government Services (RoGS)

At the MHISSC March 2013 meeting, the RoGSP Secretariat sought advice regarding a mismatch identified between inpatient bed days and separations data for the average length of stay (LOS) measure which was included for the first time with 'cost of inpatient care' information in the mental health management chapter of the 2013 RoGS. The RoGSP Secretariat queried whether it is possible or worthwhile to address data issues and the MHISSC referred the question to the NMHPSC for further advice. At its May 2013 meeting the NMHPSC considered the following two methodologies used to calculate patient days for the average LOS indicator:

- The Key Performance Indicators for Australian public mental health services average LOS indicator counts patient days linked to the separations in the reference period, including days in the previous reference period, as patient stay is calculated by subtracting the admission date from the date of separation. Patient days accrued in the reference period for patients who have not separated are therefore excluded.

- The RoGS average LOS measure uses the Mental Health Establishments (MHE) National Minimum Data Set (NMDS) aggregate patient days accrued in the reference period. Patient days from the previous reference period linked to separations in the current reference period are excluded. Patient days accrued in the reference period for patients who have not separated are included.

Following discussion and analysis, the NMHPSC agreed that the current methodology used by RoGS is appropriate, particularly, as the purpose of the RoGS measure, when considered together with cost per inpatient day, is to provide a 'proxy' measure to improve understanding of service efficiency for specialised inpatient mental health care.

10.2.4 National projects – Mental Health Non–Government Organisation (NGO) National Minimum Data Set Project and NGO Outcome Measurement Project

In February 2011, the Australian Institute of Health and Welfare (AIHW) commenced Phase 1 of the Mental Health Non–Government Organisation Establishments (NGOE) National Minimum Data Set (NMDS) Project. The Project's aim is to collect nationally consistent information on the mental health NGO sector, with Phase 1 being an annual

collection of an Establishments NMDS summarising funding, staffing and activity at an organisation level.

At the June 2013 MHISSC meeting, AIHW advised members that a second technical review has been completed by the AIHW's METeOR and Metadata Unit. Feedback from the second round has been sent to the NGO Establishments NMDS Working Group for comment. AIHW will also circulate the final specifications to MHISSC out–of–session. Final decisions about proceeding with the MH NGOE NMDS will be discussed at the October 2013 MHISSC meeting.

At the March 2012 MHISSC meeting, members agreed to commence a separate project to scope consumer outcome measurement in the Australian mental health NGO sector. DoHA agreed to fund the scoping project. The Australian Mental Health Outcomes and Classification Network (AMHOCN) is leading the project under their existing contract conditions with CMHA providing sector expertise and consultation.

A stakeholder workshop which brought together representatives from NGO peak bodies, national and state NGO funders, and consumer and carer representatives was held on 27 May 2013. Attendees discussed whether a standard suite of tools could be used by the NGO sector. A final report on the project will be delivered to the Commonwealth in July 2013 and presented at the October 2013 MHISSC meeting.

10.2.3 National project – Measuring Consumers' Experiences of Care

The Victorian Department of Health, with the support of the Commonwealth, has delivered on a national project to develop a measure of consumers' experiences of care.

A final report on the project has been completed and was presented to the MHISSC at the June 2013 meeting. The report noted that the instrument evidences sound psychometric properties, strong consumer involvement throughout all stages of its development and a clear alignment to capturing the recovery principles of the National Standards for Mental Health Services 2010. The instrument also aligns with associated measures under development, including the Carer Experience Measure and the Living in the Community Measure.

The MHISSC has endorsed the establishment of a task–specific working group to prepare a detailed proposal on the next steps for the Consumers Experience of Care Measure. The findings of the working group will be brought back to the October 2013 MHISSC meeting.

10.2.4 National project – Development of a consumer self–report measure that focuses on the social inclusion aspects of recovery

AMHOCN was commissioned by MHISSC to develop a consumer self–report measure that provides information on social inclusion outcomes. With the guidance of a technical advisory group and the Activity Participation Questionnaire as a foundation, AMHOCN created the Life in the Community Questionnaire (LCQ).

AMHOCN developed a project plan to undertake further development of the LCQ and its subsequent field testing in a range of services across states and territories. The testing will determine if the LCQ measures domains are meaningful to consumers and test the

psychometric properties of the questionnaire, including validity and reliability. AMHOCN has also undertaken a literature review of available individual–level measures of social inclusion and engaged IPSOS Social Researchers to further develop the LCQ.

At the June 2013 MHISSC meeting, AMHOCN presented a verbal report on preliminary results from the field trials and test–retest collections. MHISSC was advised that the statistical analysis of available data is currently taking place and a final report will be presented at the October 2013 MHISSC meeting.

10.2.3 Development of a carer experiences of care (family inclusiveness) measure

The Carer representative on MHISSC and the AMHOCN have undertaken work to develop a tool for measuring carers' experiences and perceptions of mental health services within a recovery framework. At the March 2011 meeting, MHISSC agreed to a project plan to modify the Victorian Consumer and Carer Experiences Questionnaire which was identified as suitable for trialling but requiring additional modification.

Modifications to the instrument have been finalised and a penultimate version of the instrument, the Carer Experience of Service Provision Measure (CEoC) went to MHISSC members at the October 2012 meeting.

A formal proof of concept trial of the CEoC Measure will be conducted in 2013 with a view to reporting the results of this trial to MHISSC in October 2013.

In order to keep the private sector focussed on the implementation of the PMHA's Patient Experiences of Care Measure (PMHA–PEx) the private sector has declined participation in the trial of the CEoC Measure, but will continue to monitor developments at MHISSC.

10.2.5 NOCC Future Directions (2012 – 2024) Review

MHISSC, via the National Mental Health Information Development Expert Advisory Panels is reviewing the NOCC suite, recommending possible changes to the measures and protocols for 2014–2024. Details of the review process can be found at http://amhocn.org/home/post/measuring–outcomes–the–road–ahead–nocc–strategic–directions–2014–2024/

Consultations have been completed. 47 forums, 22 meetings, 25 site visits and 5 videoconferences were held nationally with 860 participants and an online survey has gathered feedback from 360 individuals. A draft report will be reviewed by NMHIDEAP in July 2013 and MHISSC in October 2013

The findings from the consultations, the review of literature, the national collection over time and expert advice have been used to guide the development of the recommendations for NOCC 2014 – 2024. Final decisions regarding changes to measures or protocols may have clinical and/or resource implications and will require approval by MHDAPC. Final recommendations will be circulated to SQPSC before finalisation of the report.

11 National Mental Health Service Planning Framework

The National Mental Health Service Planning Framework (NMHSPF) is one of the key initiatives contained in the Fourth national mental health plan (specifically action 16). With funding provided by DoHA, the NMHSPF project is being led by NSW Ministry of Health in partnership with Queensland Health and other jurisdictions. The anticipated outcome of the project is to achieve a population based planning model for mental health that will better identify service demand and care packages across the sector in both inpatient and community environments. The NMHSPF will have the following characteristics:

- **Flexible and portable** – The NMHSPF will be flexible to jurisdictional adaptation, and will be presented in a user friendly format. However, some technical aspects cannot be altered or the validity of the product will be compromised.

- **Not all, but many** – To ensure national viability, the NMHSPF will not account for every circumstance or service possibly required by an individual or group, but will allow for more detailed understanding of need for mental health service across a range of service environments.

- **Not who, but what** – The NMHSPF will capture the types of care required, but will not define who is best placed to deliver the care. Decisions about service provision will remain the responsibility of each state/ territory and the Australian Government.

- **Evidence and expertise** – The NMHSPF will identify what services 'should be' provided in a general mental health service system. Contemporary mental health practice, epidemiological data and working with key stakeholders with diverse expertise will underpin the technical, clinical and social support mechanisms that will form the content of the framework.

The project is being supported by the following groups.

(1) Executive Group, made up of senior mental health representatives from all Australian jurisdictions

(2) Modelling Group

(3) Three expert working groups as follows.

- Primary Care / Community / Non Hospital Expert Working Group

- Psychiatric Disability Support, Rehabilitation and Recovery Expert Working Group

- **Inpatient/ Hospital Based Service Expert Working Group**

Consumers and carers also participate as members on the Modelling Group and each of the three expert working groups, and a Consumer and Carer Reference Group.

Ms Munro represents the PMHA on the Inpatient/Hospital Based Service Expert Working Group. Ms Munro briefed the Meeting on developments with NMHSPF and reported that Mr Morris–Yates has provided some CDMS data for the Working Group. It is anticipated that the project will be completed by the end of this year.

11. PSYCHIATRIC INTENSIVE CARE

Ms Andrea Selleck sought the advice of the meeting on what constitutes intensive psychiatric care in private sector mental health facilities.

Ms Turnbull, Ms Munro and Dr Pring clarified the situation and provided some preliminary advice, which has been summarised below.

Private hospitals often have patients who are at high risk of causing harm to themselves or others, or of absconding. Such risk is assessed by way of systems of risk assessment and tools, so that it is clear what level of observation is required. One–to–one intensive nursing care involves regular ongoing observation and risk assessment with the level of care being adjusted accordingly. It is not unusual for such care to be provide in open wards as only a few private hospitals around Australia have dedicated intensive psychiatric care units. Intensive psychiatric care is also used by private hospitals while waiting for a patient to be transferred to another facility under an involuntarily detention order. In some cases, that can be several days, with the only other option being to call an ambulance to transfer the patient to the emergency department of the nearest public hospital, if the situation is unmanageable.

Dr Bill Pring offered to write a paper on this issue for the PHA Mental health Committee.

Ms Turnbull reported psychiatric intensive care will be included in the CCMWG review of the *Guidelines for Determining Benefits for Health Insurance Benefits Purposes for Private Mental Health Care.*

Ms Selleck thanked the Meeting for its advice.

12. OTHER BUSINESS

The Chair invited Members to report on any matters not included on the Agenda.

12.1 CDMS Reports

Ms Munro reported on an issue raised last November whereby a Hospital group was asked to forward all the CDMS reports for their Hospitals to private health insurers. APHA issued a bulletin to all Hospitals participating in the PMHA's CDMS advising they are not obliged to provide that information. Despite that intervention, Hospitals are reporting to the APHA that this practice is continuing.

Ms Selleck and Ms Eriksson agreed to take this matter up with the PHA Mental Health Committee.

12.2 Promoting the CDMS outside Australia

Ms Helen Eriksson briefed the meeting on an inquiry from Ireland that raises the issue of the capacity of promoting the work of the CDMS outside Australia. The concept of the CDMS model being marketed and used by other countries was discussed. It was agreed that, in principle, this would be a good idea, but there were a range of complex issues that would need further investigation. If an opportunity arises then it should be seriously looked at.

12.3 DVA update

Mr Jonathon Wauer reported on the following DVA activities.

DVA new Mental Health Strategy has been released and is available from the at Ease website, www.at–ease.dva.gov.au.

In the 2013 budget, the Australian Government has allocated additional funding of $26.4 million over four years for veteran mental health. This package will expand access to mental health services, provide stronger mental health support for veterans, and improve claims processing. This package consists of the following seven elements.

- Expansion of access to free treatment for certain mental health conditions without the need to lodge a compensation claim. This treatment is already available to eligible veterans including with operational service, for diagnosed PTSD, anxiety and depression. The expansion will include treatment for diagnosed alcohol and substance misuse disorders and treatment will also become available to ex–serving personnel with eligible peacetime service since 1994.
- Introduction of post–discharge GP Health Assessments.
- Expansion of eligibility to Veterans and Veterans Families Counselling Service.
- LifeSMART, an on line resilience program.
- A peer to peer network in which non–clinical support will be provided to veterans with a mental health disorder.
- Improving the processing of compensation claims, with a particular focus on those individuals with a mental health condition.
- Enhanced pathways for individuals with mental health conditions to access DVA arrangements.

Most elements will start from 1 July 2014.

12.4 National Indicators and Targets for Mental Health Reform

Mr Taylor reported that the PMHA has been asked to comment on the draft framework of targets and indicators developed by the Expert Reference Group (ERG) established

by COAG to provide expert advice to governments on a set of aspirational and achievable national outcome indicators and targets for mental health that will drive transformational change and be understood by the community (refer to Agenda Item 8.3.3 above).

The Meeting considered the draft framework and in general felt that the framework appears incomplete and confuses targets with indicators. For example, *More work to do on avoidable admissions* is not an indicator, or a target. There are several examples of this nature.

Stakeholders felt that the framework should have been developed in more direct consultation with the private sector as these targets and indicators will have implications for private hospitals, private office–based practitioners, and private sector consumer and carers. The private sector plays an essential role in the overall provision of mental health services in Australia and could have added value to this major developmental activity. Mr Taylor was asked to prepare an appropriate response for the Chair outlining the PMHA's concerns and urging that consideration be given to formal representation on the ERG for an appropriate PMHA nominee.

13 NEXT MEETING

The Meeting noted the next meeting of the PMHA will now be held in Canberra as follows

21st PMHA Meeting
9:00 AM to 3:00 PM
Friday, 1 November 2013
3rd Floor AMA House
42 Macquarie Street
BARTON ACT

16 CLOSE

There being no further business, the Chair closed the Meeting at 3:00 PM.

Mr Philip Plummer
PMHA Independent Chair

Mr Phillip Taylor
PMHA Director (Secretary)