PMHA | PRIVATE MENTAL HEALTH ALLIANCE

TWENTY FOURTH (24TH) MEETING

HELD ON
FRIDAY, 7 NOVEMBER 2014
AT
AMA HOUSE
42 MACQUARIE STREET
BARTON
AUSTRALIAN CAPITAL TERRITORY

REPORT OF MEETING

Glossary of some common acronyms and terms 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
CCMWG	PMHA's Collaborative Care Models Working Group
CDMS	PMHA's Centralised Data Management Service
Commonwealth	The Australian Government
FY(s)	Financial Year(s)
HCP	Hospital Casemix Protocol
Department of Health	Australian Government Department of Health
Hospital(s)	Private Hospital(s) with psychiatric beds
HSMdb	Hospitals Standardised Measures database application of the CDMS
MHDAPC	AHMAC Mental Health/Drug and Alcohol Principal Committee
MHISSC	Mental Health Information Strategy Standing Committee of AHMAC's MHDAPC
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–PEx or PEx	PMHA's Patient Experiences of Care Measure
SQPSC	Safety and Quality Partnership Standing Committee of AHMAC's MHDAPC
SQR(s)	CDMS Standard Quarterly Reports provided to Hospitals and Payers participating in the PMHA's CDMS

1. PROCEDURAL MATTERS

The Independent Chair of the Private Mental Health Alliance (PMHA or Alliance), Mr Philip Plummer, opened the Twenty Fourth (24th) meeting of the PMHA (the Meeting) at 8:00 AM on Friday, 7 November 2014. The Meeting was held at the offices of the Federal AMA, 42 Macquarie Street, Barton in the Australian Capital Territory.

1.1 Present

PMHA Independent Chair

1. Mr Philip Plummer

Consumers and Carers

2.	Ms Janne McMahon	Consumer and Chair, Private Mental Health Consumer Carer Network (Australia) (Network)
3.	Mr Patrick Hardwick	Carer and Network Deputy Chair

Providers

4.	Professor Jeffrey Looi	AMA
5.	Dr Bill Pring	AMA
6.	Ms Moira Munro	APHA (PMHA Deputy Chair)

Payers

7.	Ms Andrea Selleck	PHA (Chair, PHA Mental Health Committee)
8.	Ms Helen Eriksson	PHA
9.	Matthew Jackson	Department of Veterans' Affairs (DVA)

Staff

10.	Mr Allen Morris–Yates	PMHA–CDMS Director
11.	Mr Phillip Taylor	PMHA Director (Chair PMHA–CCMWG)
12.	Mr Howard Pickrell	Director, AMA Corporate Services
13.	Ms Cherie Roe	AMA Financial Controller

1.2 Apologies and Alternates

1.	Ms Carol Turnbull	APHA
2.	Ms Jan Williamson	Commonwealth Department of Health
3.	Kim Werner	Network Governance and Policy Officer

1.3 Observers

1.4 Adoption of Reports of PMHA Meetings

The Meeting considered and adopted the draft Report of Twenty Third PMHA Meeting held on 13 June.

RESOLVED (Chair) carried without dissent

That the Private Mental Health Alliance (PMHA) approves, as a true and correct record, the Report of the Twenty Third PMHA Meeting, held on 13 June 2014 in Canberra, and requests the Report be made available on the PMHA website.

Action: PMHA Director

The Chair reported that all actions arising from the Twenty Third PMHA Meeting had been incorporated into Agenda Item 1.7 Table of Progress on Matters Arising and, where necessary, under relevant agenda items for this Meeting.

1.5 Table of Progress on Matters Arising

The Meeting noted the Table of Progress on Matters Arising from the 23rd PMHA Meeting as set out below.

#	23RD PMHA MEETING TABLE OF PROGRESS ON MATTERS ARISING	RESPONSIBILITY	STATUS
1.	PROCEDURAL MATTERS		
1.4	Post Report of 22nd PMHA Meeting on PMHA Website	PMHA Director	Done
	Draft and circulate Report of 23rd PMHA Meeting for review by PMHA	PMHA Director	Done
	Revise Report of 23rd PMHA Meeting based on feedback received and prepare final draft.	PMHA Director	Done
2.	PMHA WORKPLAN 2013–15		
	Agenda Item 24th PMHA Meeting	PMHA Director	Done
3.	AMA FINANCIAL STATEMENTS		
	Agenda Item 24th PMHA Meeting	PMHA Director	Done
4.	NETWORK REPORT		
	Agenda Item 24th PMHA Meeting	PMHA Director	Done
4.7	Network Survey – private patients in public hospitals		
	Obtain further information, where possible, on the following.	Ms Selleck/Ms Eriksson	Done
	i) The number of Health Fund Members admitted to public hospitals for specialised psychiatric care.		
	ii) The number of Health Fund Members admitted to private hospitals for specialised psychiatric care.		
	iii) What proportion of Health Fund Members have been admitted to both.		
5.	PMHA COLLABORATIVE CARE MODELS WORKING GROUP		
	Agenda Item 24th PMHA Meeting	PMHA Director	Done
6.	PMHA CENTRALISED DATA MANAGEMENT (CDMS) REPORT		
	Agenda Item 24th PMHA Meeting	CDMS/PMHA Directors	Done
6.1	Enable Internet–based access to the PMHA's CDMS		
	APHA, PHA, and Australian Government to seek own legal advice on AMA Internet Access Agreement.	APHA/PHA/DoH/DVA	Done
6.2	Preparation of Standard Quarterly Reports (SQRs)		
	Include the Australian clinical indicator of readmission within 28 Days of discharge from overnight inpatient care in SQRs for both Hospitals and Payers.	PMHA Director	Work Plan 2015-18
6.3	Other Reports – *PMHA CDMS Hospitals Progress Report*		
	Discuss inclusion of completion rate benchmarks in the *Guidelines for Determining Benefits for Health Insurance Purposes for Private Health Care* (Guidelines).	Ms Turnbull/Ms Eriksson	Done
	Ensure all future reports provided to MHISSC and its two appendices (ASR and Hospital Progress Report), are also routinely provided to PMHA Members.	CDMS/PMHA Directors	Done
	Seek the approval of the APHA Psychiatry Committee for wider circulation of the PMHA's CDMS Hospital Progress Report and report back to PMHA.	Ms Turnbull	Pending
	Circulate a copy of the statistics provided to the NMHC to PMHA Members, together with a copy of the updated (2014) one page report previously provided in 2012 to the then Federal Minister for Mental Health The Hon. Mark Butler MP.	CDMS/PMHA Directors	Done
	Discuss the routine inclusion in SQRs for Hospitals and Payers of the statistics provided to the NMHC with the APHA Psychiatry Committee, and report back to PMHA.	Ms Turnbull	Pending
7.	ACTIVITY BASED FUNDING AND MENTAL HEALTH		
	Agenda Item 24th PMHA Meeting	PMHA Director	Done
	Clarify the time involved in factoring into the PMHA's CDMS collection the development of routine reporting on some useful additional items that IHPA have identified that are not currently collected by private hospitals.	CDMS Director	Done

#	23RD PMHA MEETING (CONTINUED) TABLE OF PROGRESS ON MATTERS ARISING	RESPONSIBILITY	STATUS
8.	MENTAL HEALTH DRUG AND ALCOHOL PRINCIPLE COMMITTEE (MHDAPC)		
	Agenda Items for 24th PMHA Meeting on MHDAPC's Mental Health Information Strategy Standing Committee (MHISSC) and its Safety and Quality Partnership Standing Committee (SQPSC).	PMHA Director	Done
8.1	MHISSC Report		
	Attend 16/17 October 2014 MHISSC	Ms Munro	Done
8.2	SQPSC Report		
	Attend 11 July 2014 SQPSC	Dr Pring	Done
9.	DEPARTMENT OF VETERANS AFFAIRS (DVA) REPORT		
	Agenda Item 24th PMHA Meeting	PMHA Director	Done
10.	PMHA COMMUNICATION		
	Agenda Item 24th PMHA Meeting	PMHA Director	Done
10.3	PMHA Newsletter		
	Distribute the Seventeenth Edition of the PMHA Newsletter	PMHA Director	Done
11.	OTHER BUSINESS		
	Agenda Item 24th PMHA Meeting		
12.	NEXT MEETING		
	Organise 24th PMHA Meeting to be held on 7 November 2014 in Canberra	PMHA Director	Done
	Prepare and circulate Agenda and Papers for 24th PMHA Meeting	PMHA Director	Done

2. PMHA WORK PLAN 2013–15 REVIEW

The PMHA Work Plan 2013–15 was developed to broadly guide the activities of the PMHA under the auspice of the funding agreement known as the *AMA Agreement for Services 2013–15*. The Work Plan covers two Financial Years (FYs) from 1 July 2013 to 30 June 2015 and is reviewed at each meeting of the PMHA. Under that Work Plan, the PMHA is required to undertake the substantive task of developing and agreeing the next AMA Agreement for Services, its supporting budgets and work programs well before the expiration of the current Agreement.

2.1 AMA Agreement for Services and Forward Estimates 2015–17

The PMHA reviewed the first draft of the *AMA Agreement for Services 2015–17* (AMA Agreement) and it's supporting Forward Estimates for the next two FYs from 1 July 2015 to 30 June 2017. Areas that need to be addressed in the further development of the Agreement and the Forward Estimates and any other relevant matters were discussed going forward.

2.1.1 Out–of–Session Decisions

Going forward, there needs to be greater transparency around the process for how decisions are made between meetings of the PMHA, particularly where new or additional work for the CDMS is involved. While the PMHA Executive can approve such activity out–of–session those decisions and any implications for the CDMS work plan, need to be communicated to the other members of the PMHA in a timely manner between face–to–face meetings. A position for a PMHA Health Insurer representative on the PMHA Executive should be considered going forward. The CDMS report to each face–to–face meeting of the PMHA should include an opportunity to discuss any delays with agreed work plan deliverables.

2.1.2 Commonwealth Funding

The Commonwealth has advised it will not be able to confirm its contributions to the PMHA, its CDMS, or the Network, until after the National Mental Health Commission (NMHC), Review of Mental Health Programs and Services has reported to the Federal Government at the end of November. It will then take some time for the recommendations arising from the review to be considered, which may further delay confirmation of contributions, possibly until after the May 2015 Federal Budget is handed down.

2.1.3 Funding Cycle

The limitations of the AMA Agreement's two year funding cycle has become problematic.

Firstly, a two year cycle makes it more difficult for stakeholders to see budgetary peaks and troughs, particularly those related to the replacement of infrastructure for the CDMS, which usually occurs about every three years or so. Currently, hardware for the CDMS is replaced at the end of its usable life. Software is upgraded as new versions are released and licences are renewed as they fall due. Unexpected infrastructure expenditure that cannot be accommodated within the CDMS Budget is referred to the PMHA. While the system is working reasonably well, a three year Agreement would enable predictable infrastructure costs to be more clearly reflected in the Forward Estimates for stakeholders.

Secondly, the past cycle of a negotiating and developing a new agreement every two FYs has proven to be both time consuming and resource intensive, not only for PMHA, CDMS, Network and AMA personnel, but also for stakeholders.

The Meeting agreed that the next AMA Agreement, its supporting Forward Estimates and work plans for the PMHA, its CDMS and the Network should cover three FYs from 1 July 2015 to 30 June 2018.

2.1.4 Budget Surpluses and additional income

The substantive year–to–year accumulation of surpluses in the PMHA Budget (currently $25,490) and particularly the CDMS Budget (currently $41,085) needs to be addressed. The PMHA Director, Mr Phillip Taylor, anticipated that the PMHA surplus would be reduced to around $10,000 by the end of this Financial Year. To date, the CDMS has been using its accumulated surplus to accommodate unexpected infrastructure costs and for website development. The Meeting noted that the surplus in the CDMS Budget for FY 2013–14 is not the true surplus remaining from the agreed funding provided by stakeholders for that FY. It includes external income derived enrolment fees for seven new hospitals and the work undertaken for the Australian Commission on Safety and Quality in Healthcare (ACSQHC).

In FY 2014–15, there will also be $55,000 of external income derived from the funding provided by the Independent Hospital Pricing Authority (IHPA) to the CDMS for it to support private hospitals' participation in the IHPA's Mental Health Costing Study.

The Meeting then agreed that the additional $55,000 of income from IHPA was substantive. The CDMS Director was of the view that the IHPA income should be used to build on the work currently underway to facilitate internet–based access for Hospitals and Payers to the secure areas of the PMHA website. After that is in place, the IHPA funding would allow substantive work to be undertaken to develop the Standard Quarterly Report (SQR) Viewer on the PMHA website, so it can provide an ad hoc reporting mechanism for both Hospitals and Payers. This would enable Hospitals and Payers to develop their own queries of the data held by the CDMS. The Meeting agreed that the IHPA income should be included in the Forward Estimates as external income specifically allocated for this purpose.

It was agreed that going forward additional income should be treated separately from the funding provided by stakeholders, so that the true surplus remaining from the agreed stakeholder funding is clear at the end of each FY. A true surplus of up to about $10,000 would be reasonable. There must be contingency plans developed for how additional income and surpluses are to be used for the benefit of the entity concerned.

2.1.5 Work Plans

Work Plans for the PMHA, its CDMS and the Network are developed based on the routine activities that are undertaken each year. Beyond that, the respective funders of these entities are able to request any additional requirements that need to be included in these work plans, within the context of the limited resources and partnership funding available.

In considering the PMHA work plan, it was agreed that PMHA Members would forward any additional requirements to the PMHA Director by COB on Friday, 20 February next year for discussion at the 27 March 2015 PMHA meeting.

The Meeting then discussed the CDMS work plan for 2015–18 (refer also to Agenda Item 6.5 below). In doing so, the meeting revisited the risks associated with the lack of back up for the CDMS Director, Allen Morris-Yates, should he be unable to perform his role for whatever reason. After discussion, Allen was asked to give some thought to this issue and advise the 27 March 2015 PMHA meeting as to what might be able to be done to mitigate against that risk, at a feasible cost going forward. This should include the completion of the documentation of the CDMS system. Some form of part–time ongoing apprenticeship support was one suggestion. PMHA can then make an informed decision on how it wishes to proceed.

The Meeting then discussed the issue of providing access for Payers to the PMHA's Patients Experiences of Care summary statistics being provided in Standard Quarterly Reports (SQRs) to those private hospitals who have taken up Patients Experiences of Care measure. After discussion, it was agreed that the Patient Experiences of Care summary statistics should be included in Payers Standard Quarterly Reports (SQRs) for the period 1 July 2015 to 30 June 2016, which are due to be prepared and made available in the first week of October 2016. This should be sufficient time for uptake of the Patients Experiences of Care measure to be completed by private hospitals.

The Meeting noted that the Network's National Committee will meet in February to develop their work plan for submission to the 27 March 2015 PMHA meeting.

2.1.6 Way Forward

At the request of the Chair, the PMHA and CDMS Directors and the Network Chair and Deputy Chair left the Meeting. The representatives of the Parties to the current AMA Agreement that were present (AMA, APHA, and PHA) held a frank and open in camera discussion on matters relevant to the PMHA, its CDMS and the Network going forward. After that in camera discussion, the Meeting reconvened and resolved the following.

RESOLVED (Chair) carried without dissent

1. *That the Private Mental Health Alliance (PMHA) requests that the draft AMA Agreement for Services 2015–17, it supporting Forward Estimates and work plans for the PMHA, its Centralised Data Management Services (CDMS) and the Private Mental Health Consumer Carer Network (Network) be further developed to cover three Financial Years (FY) from 1 July 2015 to 30 June 2018.*

   In revising the Forward Estimates, the following must be taken into account.

   i. *A small operating surplus of $10,000 per FY is acceptable.*

   ii. *Substantive surpluses for which there are no contingency plans for real infrastructure requirements, or other necessary work, will be unacceptable going forward.*

   iii. *Stakeholder contributions should be held constant with additional budget lines developed to show how additional income and any aggregated surpluses are to be spent. For example, the additional income provided to the CDMS by the Independent Hospital Pricing Authority (IHPA) should appear as an additional income line and then separate expenditure lines should be included to show how the IHPA income is to be expended. The overall objective should be to demonstrate to stakeholders that their contributions will be constant year–on–year, with no substantive surplus at the end of each year.*

   iv. *Salaries are to be increased by 3% not 4%.*

   v. *All other relevant line items should be include a 3% increase to accommodate for fluctuations in CPI.*

   Action: PMHA/CDMS Directors/AMA

2. *The PMHA requests the CDMS Director to prepare advice for the 27 March 2015 PMHA Meeting on what might be able to be done at a feasible cost to mitigate against risk of the CDMS Director being unable to perform their role for whatever reason. This should include advice on the completion of the documentation of the CDMS system.*

   Action: CDMS Director

3. *The PMHA requests the work plan for the PMHA's CDMS for FYs 2015–18 include the provision of Patient Experiences of Care summary statistics in Payers Standard Quarterly Reports (SQRs) for the period 1 July 2015 to 30 June 2016, which are due to be prepared and made available in the first week of October 2016.*

Action: CDMS Director

4. *That the PMHA requests that Members advise of any requirements they would like to have included in the work plans for the PMHA, its CDMS and the Network for FYs 2015–18 by* ***Friday, 20 February 2015****.*

Action: PMHA Members

5. *That the PMHA requests that the Chair write to Federal Minister for Health, The Hon. Peter Dutton MP, to request a meeting to brief the Minister on the work of the PMHA and its CDMS. A meeting should also be sought with the relevant senior personnel within the Commonwealth Department of Health.*

Action: PMHA Chair/PMHA Director

3. AMA FINANCIAL STATEMENTS

Mr Taylor, reported on the AMA Statements of Income and Expenditure for the PMHA, its CDMS and the Network for the periods 1 July 2013 to 30 June 2014 and 1 July 2014 to 30 August 2014. There were no questions concerning the Statements.

RESOLVED (Chair) carried without dissent

1. *That the Private Mental Health Alliance (PMHA) adopts the AMA Statement of Income and Expenditure for the PMHA, its Centralised Data Management Service (CDMS), and the Private Mental Health Consumer Carer Network Australia (Network), for the period 1 July 2013 to 30 June 2014 (FY 2013–14).*

2. *That the PMHA notes that the surplus of $25,490 in the PMHA Budget at the end of the FY 2013–14 has been carried forward by the AMA into PMHA income stream for FY 2014–15.*

3. *That the PMHA notes that the surplus of $41,085 remaining in the PMHA's CDMS Budget at the end of the FY 2013–14 has been carried forward into the PMHA–CDMS income stream for FY 2014–15.*

4. *That the PMHA notes that the surplus of $29,594 remaining in the Network Budget at the end of the 2013–14 FY has been carried forward into the Network income stream for FY 2014–15.*

The Meeting noted that the AMA will be auditing the accounts in December 2014.

4. PRIVATE MENTAL HEALTH CONSUMER CARER NETWORK REPORT

The Private Mental Health Consumer Carer Network (Australia), or *Network* as it is commonly known, was established in 2002 to promote the interests of members of the community who receive treatment and care from private mental health services, and their carers. The activities of the Network are largely facilitated by the Network's Executive and it's National Committee (NC). The Network's NC is currently comprised as follows.

Network Chair	Ms Janne McMahon OAM
Network Deputy Chair	Mr Patrick Hardwick
Network Policy and Governance Officer	Ms Kim Werner
Network Coordinator Queensland	Mr Norm Wotherspoon
Network Coordinator New South Wales	Ms Simone Allan
Network Coordinator Australian Capital Territory	Ms Judy Bentley
Network Coordinator Victoria	Mr Evan Bichara
Network Coordinator South Australia	Assoc. Prof. Sharon Lawn
Network Coordinator Western Australia	Mr Hardwick
Network Coordinator Tasmania	Vacant
PMHA Independent Chair (Observer)	Mr Philip Plummer
PMHA Director (Meeting Secretary)	Mr Phillip Taylor

The Network's State Coordinators facilitate Advisory Forums in their jurisdictions to provide the NC with consumer and carer perspectives on issues of national significance. The Forums also provide an opportunity for State Coordinators to provide feedback on current Network activities.

The Network currently has just over 800 registered Members with 400 or so contactable by email.

The Meeting noted a copy of the draft report of the last meeting of the Network's NC held in Melbourne on 29/30 September 2014. The Chair invited the Network Chair, Ms Janne McMahon and Deputy Chair, Mr Patrick Hardwick, to report on Network activities.

4.1 Network Governance

Since the last PMHA meeting, Ms Simone Allan was appointed as the Network Coordinator for New South Wales. The Network Coordinator position for Tasmania remains vacant. The Network Chair will remain responsible for Tasmania until a coordinator can be appointed.

4.2 Carer Project

The funding for a national project to determine a best practice model for carer engagement has now been secured. ARAFMI WA is providing $100,000 toward the project and MIND Australia will contribute $100,000. The Network Chair will manage the Project and Mrs Judy Hardy will be the Project Officer. The AMA will be approached concerning

advice on the management of the funding for the Project and the employment of Mrs Hardy.

4.3 Network Survey – Private Patients in Public Hospitals

Health Fund Members are reporting that, on those occasions when they are admitted to a public hospital, pressure is brought to bear, often when they are very distressed, to elect to be treated as private patients. The Network NC has agreed that a survey of Network Members was warranted. The last meeting of the PMHA discussed the survey at length, particularly in relation to the issues around what data is currently available on the magnitude of the problem, the survey's sample population, and the approach to the survey's research methodology and analysis. PMHA agreed that the two primary parties, the Network and Health Insurers, needed to have carriage of this matter. Health Insurers agreed to obtain further information. Since the last PMHA meeting the Network's NC revised the Survey questions and forwarded them onto the health insurers.

Ms Andrea Selleck and Ms Helen Eriksson reported that Health Insurers are currently considering the Survey questions and will advise of any necessary changes. Ms Eriksson mentioned that, of the overall spend by private health insurers of around 10–15% on public sector, only a few percent is going to public hospitals for private patients. However the growth is around 15% a year, which is a concern.

4.4 Childhood Trauma and Parents as Carers

Ms McMahon is developing a discussion paper in consultation with the NC to highlight the issue of childhood trauma and parents as carers. The paper will emphasise the importance of family therapy. South West Pacific Private Hospital have offered their assistance. They have a unique Family Program whereby a person and their family can learn a number of techniques to support and transform the family of origin.

4.5 Borderline Personality Disorder (BPD)

Ms McMahon sought the PMHA's approval to release some data on South Australia (SA), extracted from the Network's national BPD Consumer and Carer Survey, to an SA politician. PMHA advised against the provision of the SA data on the basis of the sample size being far too small to be usable in any way. PMHA agreed that there is strong risk that release of the SA data would damage the reputation of the Network. It would be better to provide the entire final report on the BPD Survey.

4.6 Other activity

Mr Hardwick briefed the Meeting on his involvement on behalf of the Network with the following.

- Personally controlled Electronic Health Records
- The Mental Health Peer Work Qualification Project
- The upcoming conference on Integrating Mental Health into National Disability Insurance Scheme

- Mr Hardwick's appointment to the Board of Mental Health Australia

Ms McMahon mentioned that two invited guests attended the 29/30 September NC meeting. Ms Samantha Gavel, the Private Health Insurance Ombudsman and the Chair of the National Mental Health Commission and Patron of the Network, Professor Allan Fels AO. Ms McMahon subsequently wrote to Professor Fels concerning the Commission's National Review of Mental Health Services and Programmes and requested that the Network's Executive have the same opportunity that is being provided to public sector consumer and carer representatives to provide consumer and carer perspective in relation to the draft final report. There has been no response to date.

5. PMHA COLLABORATIVE CARE MODELS WORKING GROUP REPORT

The role of the PMHA's Collaborative Care Models Working Group (CCMWG) is to bring together providers, payers and consumers and carers as a working collaboration to identify areas of commonality and opportunity that can be developed for the benefit of all parties.

A copy of the draft report of the last meeting of the CCMWG held in Canberra on 19 September 2014 was noted and the report of CCMWG meeting held on 27 June 2014 was adopted.

In his capacity as CCMWG Chair, Mr Taylor reported that the CCMWG had now essentially completed its review of the 2012 Edition of the *Guidelines for Determining Benefits for Health Insurance Purposes for Private Mental Health Care* (Guidelines).

The Meeting noted the final draft of what will be the 2015 Edition of the Guidelines. Only one area remains to be resolved. *Therapy Group Size,* which appears in the Guidelines under *7.1 Hospitals*, is currently worded:

> ***Therapy Group Size*** *The* ***maximum*** *size of groups should not exceed 12 participants, unless additional facilitators are involved.*

CCMWG has debated whether it was still necessary to include the word ***maximum*** in the above, when in reality there are some instances where a Therapy Group may exceed 12, without the need for additional facilitators. Health Insurers agreed to discuss the proposal to remove the word ***maximum*** with their constituency. Ms Eriksson reported that the PHA Mental Health Committee had carefully considered the proposed change and unanimously agreed that the word *maximum* should be retained. This wording was originally based on advice from clinicians that was supported by consumers and carers. Funding levels have also been developed on the basis of that requirement. Beyond that, the Committee had approved all other aspects Guidelines.

Ms Munro agreed to take this matter to the next meeting of the APHA Psychiatry Committee.

RESOLVED (Chair) carried without dissent

That the Private Mental Health Alliance (PMHA) requests that the following sentence, which appears under 7.1 Hospitals in the final draft of the Guidelines for Determining Benefits for Health Insurance Purposes for Private Mental Health Care 2015 Edition, be

referred to the Australian Private Hospitals Association's Psychiatry Committee (APHA–PC).

> *"Therapy Group Size The maximum size of groups should not exceed 12 participants, unless additional facilitators are involved."*

APHA–PC is asked consider the position of Private Healthcare Australia (PHA) Mental Health Committee that the word "maximum" be retained.

Action: Ms Munro

The next meeting of the CCMWG will be held on Friday, 20 March 2015 in Canberra.

6. PMHA CENTRALISED DATA MANAGEMENT SERVICE (CDMS) REPORT

The PMHA's CDMS was established on behalf of the PMHA under the auspice of the AMA in 2001 to improve the quality of information and enable benchmarking within the private hospital sector. The CDMS works with private hospitals and health insurers to put in place efficient systems for the routine collection of outcomes data that enables the quality and efficiency of mental health service delivery to be evaluated and reported on every quarter. The CDMS Work Plan for 2013–15 now includes the following.

- Independent Hospitals Pricing Authority (IHPA) Mental Health Costing Study.
- Ongoing core tasks, which includes the preparation of Standard Quarterly Reports (SQRs) and the provision of support for participating Hospitals.
- Implementation of the PMHA-PEx measure reporting process.
- Enable internet–based access to CDMS Resources and SQRs.
- Upgrade the Hospitals Standardised Measures database application (HSMdb).
- Enhancements to all SQRs.
- Research into the identification of high–quality programs.
- Development of a CDMS Work Plan for 2015–17

The CDMS Director, Mr Allen Morris–Yates, updated the meeting on progress with these tasks.

6.1 IHPA Mental Health Costing Study

On 12 February 2014, IHPA engaged HealthConsult to undertake a mental health costing study to inform the development of the Australian Mental Health Care Classification. The costing study is being undertaken at a sample of Australian public hospitals, community mental health services and at a minimum of three private hospitals. The four private hospitals that are participating in the Study are set out below.

(1) St John of God Pinelodge in Victoria

(2) St John of God Richmond in New South Wales
(3) Toowong Private Hospital in Queensland
(4) Perth Clinic in Western Australia

In order to facilitate participation in the Costing Study, the PMHA advised IHPA that the HSMdb could be modified to enable the collection of all components of the Mental Health Costing Study Data Request Specification. Accordingly, an agreement between IHPA and the AMA was executed on 19 August 2014 for IHPA to provide $55,000 funding for the AMA to engage the Director of the CDMS to undertake the following.

- Modify the HSMdb and templates for standard data collection for the Mental Health Costing Study.
- Develop forms and detailed Training Manuals and User Guides for clinical and administrative staff.
- Distribution of the above software and other materials to the private hospitals participating in the Mental Health Costing Study.

Mr Morris–Yates briefed the Meeting on the complexities of the work that has been involved with modifying the HSMdb and templates for standard data collection for the Study.

Ms Moira Munro, as CEO of the Perth Clinic, reported on the additional work and staff that have been required to ensure that the data is collected correctly for IHPA at Perth Clinic.

The outcome of this work will mean that the CDMS will have the classification component of the answer to the question – how do you identify effective care? This would help to progress the previously agreed task in the CDMS work plan, which relates to research into the identification of high–quality programs, and how we classify cases.

6.2 Standard Quarterly Reports (SQRs)

Production of SQRs will be delayed while the work for IHPA is completed by the CDMS.

Under this agenda item the special situation of one facility in Western Australia, which is shared with a few other facilities participating in the PMHA CDMS, was discussed as set out below.

(1) It is clear that the facility is gazetted at both the State and Commonwealth levels as a private hospital and, given that it operates a psychiatric unit, it is from the CDMS's perspective in scope. (2) The vast majority of their admissions are for patients, notionally defined as 'public patients', whose care is paid for by WA Health. (3) For those patients, the facility is obliged to collect and submit to WA Health outcome measures data collected in accordance with WA Health's implementation of the *National Outcomes and Casemix Collection* (NOCC) protocol. (4) Health Funds are clear in their requirement that, for their members, the facility should collect and report outcome measures in accordance with the *PMHA's National Model for the Collection and Analysis of a Minimum Data Set with Outcome Measures for Private Psychiatric Services* (National Model).

Enrolment of the facility in the CDMS poses a number of important policy issues for the CDMS, which require further clarification from a PMHA policy level regarding the more general issue of what we expect from hospitals like this one in WA that are enrolled, or wish to enrol, in the CDMS.

(5) For private hospitals with psychiatric beds the scope of the collection of data under the PMHA's National Model includes all separations with either or both non–zero Total Psychiatric Care Days and a Principal Diagnosis that is among the set of diagnoses defined as indicating a need for specialist mental health care (almost all diagnoses in MDCs 19 and 20). (6) All patients that meet criteria (5), regardless of Payer and regardless of where in the hospital they are admitted, are in scope.

If the above to inclusion criteria were to be strictly applied to this facility they would need to submit data on all psychiatric separations. Given that for the majority of such separations they must already collect and submit data to WA Health using whatever systems they have built, or been provided with to enable that, submission of data to the CDMS would then require that that data also be entered into HSMdb. Such double entry of data would be onerous.

Accordingly, it is proposed that in the case of WA facility concerned, and any other private hospitals in similar circumstances (none other currently subscribes to the CDMS) the following be accepted as the statement of the inclusion criteria.

(7) For private hospitals with psychiatric beds that operate 'public' acute psychiatric units within which private patients may be admitted, or which operate such 'public' units alongside of other 'private' psychiatric units, the scope of the collection of data under the PMHA's National Model will include: All separations that meet criterion (5) above, and; (8) for whom the Payer is NOT identified as the State Health Department within whose jurisdiction the hospital operates. (9) All separations where the Payer is of any other class, including health insurance funds, Department of Veterans' Affairs (DVA), workcover authorities and other third–party payers, and overseas visitors not admitted as public patients are in scope. (10) Application of criterion (8) is not mandatory, that is, such a hospital may choose to submit data on all patients that meet criterion (5).

The implementation of the above criteria (7), (8) and (9) in conjunction with (5) will require two things from the hospital. First, HCP episode records extracted from the hospital's patient administration system MUST include a Payer Identifier that reliably identifies separations where the Payer is the State Health Department, but which does NOT also apply to any separations whose Payer is among those identified by criterion (9). Second, the hospital will need to implement reliable procedures to ensure that all patients that do meet criterion (5) and (9) are included in the collection of outcome measures and other related data as required under the PMHA's National Model. If the hospital is unable to do both the preceding then the CDMS will be unable to reliably process the data provided by the hospital.

The CDMS is of the view that the above provides a clear and fair basis for the WA facilities participation in the CDMS.

After discussion, Ms Eriksson took this proposal on notice and will report back to the next meeting of the PMHA on the view of Heath Insurers.

6.3 Implementation of the Patient Experiences of Care reporting process

Implementation of the reporting process for the PMHA Patient Experiences of Care (PMHA–PEx) measure is progressing well.

6.4 New Enrolments

Since the last PMHA meeting, Blackwood River Clinic, located near Nannup in the South West of Western Australia, has paid its enrolment fee to participate in the PMHA, CDMS and the Network. Blackwood River Clinic offers day–only services and is licenced to treat a maximum of 30 patients at any one time. Training for this facility was not required.

6.5 CDMS Work Plan 2015–18

The ongoing core routine tasks to be included in the work plan for the CDMS in FYs 2015–18 are clearly set out under Clause *3 CDMS* in *Schedule A – Services and Deliverables* of the AMA Agreement for Services. These routine tasks include:

- Maintaining the CDMS Data Warehouse
- Managing the process for Hospital data submission to the CDMS
- Producing and distributing SQRs to Hospitals and Payers
- Providing support and training materials for participating Hospitals
- Maintaining the HSMdb software

There is a lot of work related to maintaining the CDMS Data Warehouse and the HSMdb that has been put on hold for the past two FYs, because of the work that the CDMS was required to undertake as part of the PMHA's Quality Improvement Project. This work included the development, testing, revision and implementation of the PMHA–PEx measure for Hospitals. The work that was put on hold included upgrade of the CDMS Data Warehouse software to enable major enhancements of SQRs for both Hospitals and Payers. That work must be the priority in the first two FYs of the CDMS Work Plan for FYs 2015–18. Enhancements will include the following.

- Incorporation of the established Australian clinical indicator of readmission within 28 Days of discharge from overnight inpatient care.
- Useful additional items from the IHPA National Activity Based Funding (ABF) Mental Health Classification, if judged to be fit for purpose by PMHA. This will enable the analysis of programs requested by Health Insurers under the current work plan.

To facilitate those enhancements will require the CDMS Data Warehouse platform to be stabilised in the first two FYs of the next work plan.

As agreed under Agenda Item 2.1.5 above, an additional task for the CDMS work plan will be the initiation of the inclusion of summary statistics regarding Patients

Experiences of Care in Payer SQRs. Those statistics will first appear in the SQRs for the period 1 July 2015 to 30 June 2016, which are due to be prepared and made available in the first week of October 2016.

Any further additional requests for the CDMS Work Plan need to be submitted no later than **Friday, 20 February 2015**.

6.6 Enabling internet–based access to CDMS Resources and SQRs

The last PMHA meeting considered the final draft AMA contract to facilitate internet–based access for Hospitals and Payers to the secure areas of the PMHA website. That Meeting gave its "in principle" endorsement for the contract, noting that APHA, PHA, and the Australian Government would need to seek their own legal advice before the contract could be fully endorsed.

DVA subsequently reviewed the draft Agreement and advised that they don't see any issues with the proposed agreement. DVA will sign once it's finalised. This acceptance is on the understanding that there is no change to the agreement DVA reviewed and the final agreement submitted.

The Meeting noted that there will be no ongoing costs associated with the provision of internet–based access to CDMS Resources and SQRs beyond the routine budgeted costs for maintaining the PMHA website.

Ms Eriksson reported that Health Insurers have some concerns around the definition of confidentiality under Clause 3.1, which currently reads:

> *Confidential Information means information relating to the development, layout, programming and operation of the CDMS–IS, and any other information with respect to the business, finances, trade secrets or know–how of AMA or the PMHA that may be communicated to You (whether by AMA or otherwise) during the term of this Agreement, but excludes information that is in, or subsequently enters, the public domain other than through a breach of this agreement by You.*

The concern relates to the end of this definition underlined above, which may be interpreted to mean the only information Health Insurers can use and share with another party would be information that is available in the public domain. The information Health Insurers receive about the Hospitals performance in SQRs is not something that is in the public domain. Mr Morris–Yates explained the clause means information relating to the …*development, layout, programming and operation of the CDMS–IS and any other information with respect to the business, finances, trade secrets or know–how of AMA or the PMHA…*, it has nothing to do with the content of the SQRs produced by the CDMS. Ms Eriksson will take this back to Health Insurers.

7. ACTIVITY BASED FUNDING AND MENTAL HEALTH

In December 2012, the Independent Hospital Pricing Authority (IHPA) decided that a new mental health classification would be developed for mental health services in Australia for the purposes of activity based funding (ABF). IHPA recognised that the Australian Refined Diagnosis Related Groups (AR–DRGs) was not the ideal classification in the longer term for mental health services, primarily because diagnosis

is not as strong a driver of resource utilisation for mental health services, as it is in other acute services.

The development of the Australian Mental Health Care Classification (AMHCC) was foreshadowed in successive Pricing Frameworks and Three Year Data Plans, as well as through the IHPA Jurisdictional Advisory Committee and IHPA's Mental Health Working Group (MHWG). At the Standing Council on Health meeting in April 2014, IHPA re–affirmed its commitment to develop the AMHCC Version 1.0 for implementation trials in 2015–16.

It is anticipated that the development of the AMHCC will significantly improve the clinical meaningfulness of the classification leading to an improvement in the cost predictiveness and will support the new models of care being implemented in the public sector in all jurisdictions.

The following work has been undertaken to date.

- The University of Queensland Definitions and Cost Drivers Report, published in 2013.
- Endorsement of the Mental Health Care Type definition by IHPA in 2013.
- The development of the ABF Mental Health Care Data Set Specification (DSS).
- The commencement of the Mental Health Costing Study at study sites from 1 July 2014.

The next phase of work is the development of the classification by 30 June 2015 for implementation trials in 2015–16 and commencement of pricing on 1 July 2016. Essentially, there are three stages to the project.

Stage	Timeframe
Stage 1: AMHCC Architecture Develop the framework for the classification system based on the theoretical design and analysis of the mental health costing study data.	October 2014 – February 2015
Stage 2: AMHCC Version 1.0 Undertake data analysis and testing of the framework using the mental health costing study data and undertake a pilot of AMHCC V1.0. Best efforts collection of the MHC DSS from 1 July 2015.	March 2015 – November 2015
Stage 3: AMHCC Version 2.0 Refine the DSS and publish MHC DSS V2.0 for FY2015–16. Refine the AMHCC, develop the associated infrastructure and finalised AMHCC V2.0.	December 2015 –June 2016

This work will be guided by a Mental Health Classification Expert Reference Group, which reports to IHPA's MHWG. Public consultation has been built into to each stage of the classification's development.

8. DEPARTMENT OF VETERANS' AFFAIRS (DVA)

Mr Matthew Jackson briefed the Meeting on DVA's Peer to Peer Support Network Forum, which will be hosted by The Prime Ministerial Advisory Council to support veterans and ex–servicemen and women in need. The Forum will be held in Canberra on Wednesday, 26 November 2014 at the Australian War Memorial. The Forum aims to improve understanding of the nature and prevalence of mental illness amongst serving and ex serving personnel and current treatment pathways. Keynote speakers include:

- Dr Stephanie Hodson, the Department of Veterans' Affairs
- Dan O'Brien–Mazza, Mental Health Services, USA Veterans' Affairs
- Michael Burge OAM, Mental Health Consumer Advocate and Mental First Aid Facilitator
- Veronica Hancock, the Department of Veterans' Affairs

DVA has completed the round of tenders for the provision of Private Hospital Mental Health Services. DVA have contracted with 18 entities and 59 facilities. In doing so, DVA took a new approach to purchasing outpatient programs, which involves a very strong emphasis on evidence base and targeting particular mental health conditions. Experts from the Australian Centre for Posttraumatic Mental Health assisted with assessing the proposals for four categories of outpatient programs.

1. Grand Parented Programs (where DVA clients are already insitue)
2. Innovative Programs
3. Post–Traumatic Stress Disorder Programs
4. Clinical Day Programs.

DVA has established contracts for about 86 Clinical Day Programs and 43 Grand Parented Day Programs. The new approach provided opportunity to learn about how to communicate with the industry in relation to what DVA required and how that can be obtained within the Commonwealth's strict tendering and procurement framework.

The DVA Guide to Clinical Mental Health Outpatient Day Programs will be available on the DVA website shortly.

9. MENTAL HEALTH DRUG AND ALCOHOL PRINCIPLE COMMITTEE

The Australian Health Ministers Advisory Council (AHMAC) Mental Health/Drug and Alcohol Principal Committee (MHDAPC) is comprised of Senior Government Officials. The role of the MHDAPC is to advise AHMAC on national mental health, alcohol, tobacco, and other drug issues. The PMHA is linked to the work of the MHDAPC through the positions it holds on MHDAPC's Safety and Quality Partnership Standing Committee (SQPSC) and its Mental Health Information Strategy Standing Committee (MHISSC). The PMHA is represented on the SQPS by Dr Bill Pring and on MHISSC by the PMHA Deputy Chair, Ms Moira Munro.

MHDAPC last met via teleconference on 12 August 2014 to progress business matters of the MHDAPC and its standing committees.

9.1 SQPSC Report

The SQPSC is responsible for taking the Australian Government mental health safety and quality agenda forward. The Meeting noted a copy of the minutes of the SQPSC meeting held on 11 July 2014 in Melbourne and the agenda for the SQPSC meeting to be held next week on 14 November 2014 in Melbourne. The PMHA Representative on the SQPSC, Dr Bill Pring, provided a verbal briefing for the Meeting. A summary of key developments is set out below based on the verbal report provided by Dr Pring and additional information extracted from SQPSC reports and summaries.

9.2.1 Reducing Adverse Medication Events in Mental health Services

At the July 2014 SQPSC meeting a presentation given by Professor Libby Roughead, who is a research Professor at the School of Pharmacy and Medical Sciences at the University of South Australia. Professor Roughead provided considerable research and data to inform the direction of medication safety work undertaken by the SQPSC. The SQPSC noted the national medication safety project focus (previously agreed by MDAPC for a project on monitoring antipsychotic use) had been revised to build on the work of Professor Roughead. The revised scope for the project includes a survey of Australian mental health inpatient units regarding interventions and prescribing issues, looking at mechanisms in mental health services to reduce errors. The project is a priority for the 2014–2015 SQPSC work plan. This project has dependencies with other national initiatives, in particular the proposed scoping study by the Australian Commission on Safety and Quality in Health Care (ACSQHC) on medication safety issues in mental health across all sectors. Dr Pring is on the SQPSC Sub–committee that will be working on this project with ACSQHC.

9.2.2 Physical Health and Wellbeing of People with Mental Health Issues

The physical health and wellbeing of people with mental health issues and the quality of care is an area of major concern. The current SQPSC work plan includes a goal to promote the physical health and wellbeing of people with mental health issues, however, a specific work program activity is yet to be undertaken. At the July SQPSC meeting members agreed to:

- contribute to a more detailed collection of jurisdictional physical care material;
- review and utilise the SQPSC GovDex community site as a repository for physical health and other safety and quality material relevant to SQPSC; and
- work with the Mental Health Information Strategy Standing Committee (MHISSC) regarding physical health care indicator development and invite Dr Grant Sara, MHISSC Chair, to present a session on physical care indictor development based on the presentation to the NSW Clinical Advisory Council.

SQPSC is now including Physical Health Care on the SQPSC meeting agenda as a standing discussion item. While the focus for SQPSC is likely to be on the side effects

of medication and metabolic syndrome, there is also recognition that there is a broader number of physical health problems that people with a mental illness experience.

9.2.3 National Community Managed Organisations (CMO) Outcomes Measures

Australian Mental Health Outcomes and Classification Network (AMHOCN), in collaboration with Community Mental Health Australia (CMHA), is working on the use and potential standardisation of outcome measurement tools for use in mental health community managed organisation (CMO) sector. The final project report included several recommendations to progress the use of outcome measurement within the mental health community managed organisation sector. A project was conducted during 2013 and current activity is focussed on measures that are suitable for use within the CMO sector within the context of the following domains.

- Experience of service
- Recovery
- Thoughts and feelings
- Daily living and relationships
- Social inclusion
- Multidimensional
- Quality of life

9.2.4 Recovery Oriented Care

In 2013, the Australian Health Ministers' Advisory Council (AHMAC) endorsed a *National recovery oriented framework for mental health services* (the Framework), which was launched at the 2013 TheMHS Conference. A National Implementation and Communication Strategy was endorsed by MHDAPC on 7 February 2014. At the 11 July 2014 SQPSC meeting members agreed the promotion, implementation and review of the *Framework* remains a priority on the SQPSC 2014–15 Work Plan. Members also noted further scoping will be undertaken once project officer support is in place. Recovery oriented care remains a recurring agenda item for SQPSC consideration of opportunities to progress work in this area.

9.2.5 Seclusion and Restraint 2013–14 ad hoc collection

At present there is no formal, routine nationally agreed collection and reporting framework for seclusion and restraint data in specialised mental health public acute hospital services in Australia. However, data from the 'ad hoc' seclusion collection was reported for the first time in 2013 via the Mental Health Services in Australia (MHSA) website.

In October 2013, the National Seclusion and Restraint Data Working Group (NSRDWG) submitted a paper to the Mental Health Information Strategy Standing Committee (MHISSC) suggesting enhancements to the 'ad hoc' seclusion data collection and the implementation of an inaugural 'ad hoc' restraint data collection for 2013–14. MHISSC endorsed, in principle, the following proposed enhancements to the ad hoc seclusion collection:

Enhancement 1: Report aggregate seclusion data for states and territories by target population and separate data for the 'mixed' target population

category to improve the capacity to report the target population sub–groups within these hospitals.

Enhancement 2: Collect and report the total number of people secluded.

Enhancement 3: Collect and report the total time spent in seclusion.

Enhancement 4: Include the total number of separations (including statistical separations for the collection year).

MHISSC also endorsed, in principle, the collection and reporting of an inaugural 'ad hoc' restraint data collection with restraint data to be collected against 3 categories: mechanical restraint, physical restraint and unspecified mechanical or physical restraint.

In July 2014, the AIHW requested supply of 2013–14 seclusion and restraint data via jurisdictional SQPSC members. Data was received from 7 jurisdictions. AIHW undertook a preliminary analysis of the submitted data and is currently working with jurisdictions to validate these data against previous submissions.

The NSRDWG subsequently discussed the quality of seclusion and restraint data supplied and to determine if data are fit for publication.

Seclusion Data

Overall, the NSRDWG recommendation to SQPSC and MHISSC that the 2013–14 ad hoc seclusion data, including the data enhancements, were fit for purpose and suitable for publication. Six jurisdictions supplied the additional seclusion data elements with appropriate caveats where indicated. One jurisdiction was unable to provide all the requested additional seclusion data elements. The AIHW is currently exploring the potential supply of the additional data elements with that jurisdiction.

Restraint Data

NSRDWG was of the view that the 'ad hoc' restraint data in its current form was not fit for publication. Six jurisdictions supplied restraint data for the first time as part of the 2013–14 'ad hoc' restraint data collection. Preliminary analysis of the supplied restraint data identified considerable variation in the number of restraint events across jurisdictions and restraint categories. This demonstrates a variation in restraint reporting, practice and legislation across jurisdictions, which make it difficult to draw meaningful comparisons. Due to the considerable variation in reporting of restraint events across jurisdictions the NSRDWG is of the view that the 2013–14 restraint data are not fit for purpose and should not be published at this time. However, the NSRDWG recognises that this inaugural collection of restraint data is an important first step towards the publication of comparable, national restraint data. SQPSC and MHISSC are working collaboratively with jurisdictions to review these preliminary results with a view to developing a common, 'working' definition of restraint that can be used to improve the quality of the restraint data being supplied for the 2014–15 collection period.

9.2 MHISSC Report

MHISSC provides expert technical advice and recommendations on initiatives to address the information requirements for MHDAPC. MHISSC is a large Committee that meets over two days three times a year.

The Meeting noted the copy of the minutes of the MHISSC meeting held on 5/6 June 2014 in Sydney and the agenda of the MHISSC meeting held on 16/17 October 2014 in Melbourne. The PMHA Representative on the MHISSC, Ms Moira Munro, attended the June and October MHISSC meetings.

In the time remaining, Ms Munro reported that Mr Morris–Yates provided a presentation for October 2014 MHISSC meeting on the development and implementation of the PMHA–PEx outcome measure for private hospitals. The presentation was well received with many positive comments about what has been achieved. The National Mental Health Consumer Experiences of Care Instrument for the public sector is progressing and interest in these instruments appears to be growing.

10. 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. The Meeting then considered and approved the Eighteenth Edition of the PMHA Newsletter for release in December 2014.

RESOLVED (Chair) carried without dissent

That the Private Mental Health Alliance (PMHA) approves the Eighteenth Edition of the PMHA Newsletter for release in December 2014.

Action: PMHA Director

11. OTHER BUSINESS

There was no other business.

12. NEXT MEETING

The Meeting agreed that the next meeting of the PMHA will be held as follows.

PMHA Face–to–Face Meetings 2014			
Meeting	Time	Date	Venue
25th PMHA	8:00 AM – 2:00 PM	Friday, 27 March 2015	3rd Floor Conference Rooms AMA House 42 Macquarie Street Barton Australian Capital Territory
26th PMHA	8:00 AM – 2:00 PM	Friday, 12 June 2015	

13. CLOSE

There being no further business, the Chair closed the Meeting at 2:00 PM.

Mr Philip Plummer
PMHA Independent Chair

Mr Phillip Taylor
Secretary