PMHA | PRIVATE MENTAL HEALTH ALLIANCE

SIXTEENTH MEETING

HELD ON

FRIDAY, 30 MARCH 2012

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
AHIA	Australian Health Insurance Association
AHMAC	Australian Health Ministers Advisory Council
AMA	Australian Medical Association
APHA	Australian Private Hospitals Association
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
PMHA	Private Mental Health Alliance
PMHA–CCMWG	PMHA Collaborative Care Models Working Group
PMHA–CDMS	PMHA Centralised Data Management Service
RACGP	Royal Australian College of General Practitioners
SQPS	Safety and Quality Partnership Sub–committee of the MHSC

1 OPENING AND WELCOME

The Independent Chair of the Private Mental Health Alliance (PMHA), Mr Philip Plummer, opened the Sixteenth (16th) Meeting of the PMHA (the Meeting) at 9:00 AM on Friday, 30 March 2012. 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

Chair

1.	Mr Philip Plummer	PMHA Independent Chair

Consumers and Carers

2.	Ms Janne McMahon	Private Mental Health Consumer Carer Network (Australia) [Network] Consumer Representative
3.	Mr Patrick Hardwick	Network Carer Representative

Providers

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

Payers

8.	Ms Helen Eriksson	Private Healthcare Australia (PHA)
9.	Ms Andrea Selleck	PHA
10.	Ms Robyn Milthorpe	Australian Government Department of Health and Ageing (DoHA) Mental Health System Improvement Branch

Staff

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

1.2 Apologies

1.	Ms Isabel Leal	DoHA Private Health Insurance Branch
2.	Ms Christine Reed	Department of Veterans' Affairs (DVA)

2. REPORT OF THE LAST (FIFTEENTH) PMHA MEETING

The PMHA adopted the report of its last meeting after minor amendment.

Resolved (unanimous)

That the Private Mental Health Alliance (PMHA) adopts the Report of the Fifteenth PMHA Meeting held on 21 October 2011 in Adelaide, 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 WORK PLAN

Under this Agenda Item, the Meeting updated the Table of Progress on Matters Arising from the last meeting and also reviewed the PMHA Work Plan 2011–13.

3.1 Table of Progress on Matters Arising from the 15th PMHA Meeting

#	TABLE OF PROGRESS ON MATTERS ARISING FROM THE 15TH PMHA MEETING	RESPONSIBILITY	STATUS
2	PMHA MEETING REPORTS		
	Post Report of 14th PMHA Meeting on PMHA Website	PMHA Director	Done
	Draft and circulate for comment Report of 15th PMHA Meeting held on 21/10/11	PMHA Director	Done
	Revise Report of 15th PMHA Meeting and prepare final.	PMHA Director	Done
	Agenda Item 16th PMHA Meeting.	PMHA Director	Done
4	AMA FINANCIAL STATEMENTS		
	AMA to recover 2010–11 contributions to PMHA/CDMS from 2011–12 Budgets	PMHA Director/AMA	Done
	Agenda Item 16th PMHA Meeting.	PMHA Director	Done
5	PMHA OPERATING GUIDELINES 2012–13		
	Revise Guidelines based on 15th PMHA Meeting with AMA Legal Counsel (LC)	PMHA Director/AMA LC	Done
	Agenda Item 16th PMHA Meeting	PMHA Director	Done
6	PMHA COLLABORATIVE CARE MODELS WORKING GROUP		
	Publish revised Guidelines as 2012 Edition at the end of 2011.	PMHA Director	Done
	Agenda Item 16th PMHA Meeting	PMHA Director	Done
7	PMHA QUALITY IMPROVEMENT PROJECT (QIP) STEERING COMMITTEE REPORT		
	Agenda Item 16th PMHA Meeting	PMHA Director	Done
8	PMHA CENTRALISED DATA MANAGEMENT (CDMS) REPORT		
	Agenda Item 16th PMHA Meeting	PMHA/CDMS Directors	Done
9	PMHA COMMUNICATION		
	Agenda Item 16th PMHA Meeting	PMHA Director	Done
9.1	PMHA Newsletter		
	Draft and circulate 10th PMHA Newsletter for approval, then publish widely with –	PMHA Director	Done
	Guidelines for Determining Benefits for Health Insurance Purposes for Private MH Care 2012	PMHA Director	Done
10	PRIVATE MENTAL HEALTH CONSUMER CARER NETWORK (NETWORK) REPORT		
	Agenda Item 16th PMHA Meeting	PMHA Director	Done
10.9	Borderline Personality Disorder (BPD) Awareness Day		
	Explore the feasibility of holding the BPD Awareness Day in Adelaide in 2012	Network Chair	Done

#	TABLE OF PROGRESS ON MATTERS ARISING FROM 15th PMHA MEETING (continued)	RESPONSIBILITY	STATUS
10.10	Network BPD Consumer and Carer Survey		
	Forward list of final comments to Professor Lawn by COB on 28/10/11.	CDMS Director/Network Chair	Done
	Ascertain if Professor Lawn is able to revise BPD Report by the end of November 2011.	Network Chair	Done
	Review any revised report on the BPD survey results for the PMHA via email	Prof Page/ Mr Morris–Yates/ Ms Rosenfeld	Done
10.11	BPD Informal Contact Group		
	Advise BPD Informal Contact Group Members of the progress with the BPD Survey.	Network Chair	Done
	Offer Members to become members of the Network	Network Chair	Done
	Include those who wish to join Network on the Network database at the AMA.	PMHA Director	Done
	Destroy list of BPD Informal Contact Group Members	Network Chair	Done
10	MHSC REPORT		
	Represent the PMHA at the PFSIC Meeting on 23 November	PMHA Chair	Done
	Represent the PMHA at the 24 November 2011 MHSC Meetings	PMHA Deputy Chair	Done
	Agenda Item 16th PMHA Meeting	PMHA Director	Done
12	MHSC SQPS REPORT		
	Represent the PMHA at the 19 November 2011 SQPS Meeting	Dr Pring	Done
	Agenda Item 16th PMHA Meeting	PMHA Director	Done
13	MHSC MHISS REPORT		
	Represent the PMHA at the 3/4 November 2011 MHISS Meeting	PMHA Deputy Chair	Done
	Agenda Item 16th PMHA Meeting	PMHA Director	Done
14	OTHER BUSINESS		
	Agenda Item 16th PMHA Meeting	PMHA Director	Done
15	NEXT MEETING		
	Organise 16th PMHA Meeting for 30 March 2012 @ Adelaide Clinic	PMHA Director	Done
	Prepare and circulate Agenda and Papers for 16th PMHA Meeting	PMHA Director	Done

The PMHA Director, Mr Phillip Taylor, reported that there were no matters outstanding from the last PMHA meeting and any further commentary on follow–up actions had been included under appropriate agenda items for this Meeting.

3.2 PMHA Work Plan 2011–13

The Meeting revisited the PMHA Work Plan 2011–13 and felt it was tracking well with much having been achieved since its implementation on 1 July 2011. The Meeting then discussed the following matters in relation to the PMHA's work program over the next 15 months.

3.2.1 AMA Agreement for Services 2013–15

The current funding agreement (*AMA Agreement for Services 2011–13* or Agreement) that supports the activities of the PMHA, its Centralised Data Management Service (CDMS) and the Private Mental Health Consumer Carer Network (Australia) [hereafter PMHCCN or Network] will expire on 30 June 2013. Any subsequent Agreement will need to be finalised and in place by 1 July next year. Over the coming months, Mr Taylor, in consultation with the CDMS Director, Mr Allen Morris–Yates, and the Network Chair, Ms Janne McMahon, will begin drafting the next Agreement, its supporting budgets, and work plans for preliminary discussion at the last meeting of the PMHA for 2012. It should then be possible to finalise this work at the first meeting of the PMHA in 2013.

Mr Taylor asked whether there were any matters that needed to be taken into account in the drafting of the next Agreement.

A discussion of the uncertainties of the current political and economic climate that carry implications for the PMHA's core funders (AMA, AHIA, APHA and DoHA) followed. Notwithstanding these uncertainties, the PMHA agreed that drafting of the next Agreement should proceed strictly on the basis that core funders would not be able to support any increase in expenditure beyond a possible small increase to account for CPI.

Resolved (unanimous)

That the Private Mental Health Alliance (PMHA) requests that the next AMA Agreement for Services 2013–15, to support the activities of the PMHA, its Centralised Data Management Services and the Private Mental health Consumer Carer Network (Australia) from 1 July 2013 to 30 June 2015 be drafted. The Agreement, its supporting budgets and work plans, should be prepared strictly on the basis of no increases in expenditure, beyond a possible CPI increase. Preliminary drafts should be included on the agenda for discussion at the last meeting of the PMHA in 2012.

Action: PMHA Director /CDMS Director/Network Chair

3.2.2 Meeting with the Minister for Mental Health and Ageing

The Meeting discussed the PMHA's previous invitation for The Hon. Mark Butler MP, Minister for Mental Health and Ageing, Minister for Social Inclusion, and Minister Assisting the Prime Minister on Mental Health Reform, to attend a meeting of the PMHA in Adelaide. The difficulties involved in getting time with Minister Butler were discussed and it was noted that the APHA is experiencing similar delays. It was agreed that it may be more appropriate for a small delegation from the PMHA to seek a meeting with the Minister at his convenience. The purpose of the meeting should be to discuss the work of the PMHA and the usefulness of the CDMS outcomes data in the context of reporting on mental health. The PMHA should also offer to assist the new National Mental Health Commission with the provision of data.

Resolved (unanimous)

That the Private Mental Health Alliance requests that the Chair write again to The Hon. Mark Butler MP, Minister for Mental Health and Ageing, Minister for Social Inclusion, Minister Assisting the Prime Minister on Mental Health Reform to request a meeting with the Minister at his convenience when in Adelaide, or in Canberra.

Action: PMHA Chair /PMHA Director

3.2.3 National Mental Health Commission

The Meeting discussed the new National Mental Health Commission (NMHC or Commission), which the Prime Minister has established as an Executive Agency within her portfolio to recognise the important cross sectoral leadership role the Commission will play in mental health reform. The Commission will be overseen by Minister Butler and undertake the following.

- Manage and administer the annual *National Report Card on Mental Health and Suicide Prevention*.

- Monitor and report on the performance of the mental health system including through ongoing evaluation of the Ten Year Roadmap for Mental Health Reform which is currently being developed.

- Develop, collate and analyse data and reports from other sources including Commonwealth agencies reporting on progress – with a particular focus on ensuring a cross sectoral perspective is taken to mental health reform.

- Provide mental health policy advice to Government in consultation with relevant agencies.

- Engage consumers and carers in mental health policy and service improvements.

In June 2011, Ms Robyn Kruk AM was appointed as CEO–designate of the Commission. Ms Kruk has almost 30 years of significant public sector experience, including as Director General of NSW Health and Director General of the NSW Department of Premier and Cabinet.

After discussion, it was agreed that Ms Kruk should be invited to attend the next meeting of the PMHA to discuss the work of the Commission.

Resolved (unanimous)

That the Private Mental health Alliance (PMHA) requests that the Chair invite the Chief Executive Officer of the National Mental Health Commission (NMHC), Ms Robyn Kruk AM, to attend a meeting of the PMHA.

Action: PMHA Chair/PMHA Director

3.2.4 National Report Card on Mental Health and Suicide Prevention

Mr Taylor reported on the invitation received from Mr Robert Merriel, Associate Director of Healthcare Management Advisors (HMA). HMA has been engaged by the NMHC to undertake the development of a blue print and implementation plan for the annual *National Report Card on Mental Health and Suicide Prevention*.

HMA is seeking to meet with the PMHA to discuss options for this proposed Report Card. The Meeting noted the tight timelines and agreed that a meeting should be arranged with Mr Merriel during the HMA consultations to be held in Canberra from 11 to 13 April 2012. Mr Morris–Yates agreed to participate via teleconference with other available non-government Members of the PMHA.

The Meeting agreed a brief for HMA should be prepared and Members were asked to forward any comments they might wish to make to Mr Taylor before the Easter holiday break.

Resolved (unanimous)

That the PMHA requests that a meeting be arranged between PMHA non–government Members and the consultants Healthcare Management Advisors (HMA) to discuss the development of the National Report Card on Mental Health and Suicide Prevention for the National Mental Health Commission. A brief for HMA should be prepared by the PMHA and CDMS Directors.

Action: PMHA Director/CDMS Director

4. AMA FINANCIAL STATEMENTS

The Meeting considered the Statement of Income and Expenditure for the PMHA, its CDMS, and the Network, for the period 1 July 2011 to 31 December 2012, prepared by the AMA.

The Chair noted that Expenditure in all three budgets was running ahead due to infrastructure and other costs, and requested that care be exercised over the next few months to ensure the budgets are not in deficit at the end of this Financial Year (FY).

Mr Taylor reported on some of the Expenditures responsible for the current budget position.

- The additional contributions made by the AMA to the 2009–10 FY Budgets of $3,413 for the PMHA and $13,650 for the CDMS, had now been recovered by the AMA. These additional contributions had been kindly made by the AMA to account for Long Service Leave adjustments for the PMHA and CDMS staff to enable the PMHA and its CDMS to retain their operating surpluses at the end of the 2009–10 FY. The PMHA subsequently agreed it would endeavor to secure some form of recovery for the AMA. At its 22 October 2011 meeting, PMHA agreed that the surplus funds available at the end of the 2010–11 FY were such that the AMA could safely recover those additional contributions.

- The entire AMA administration fee for PMHA, its CDMS and the Network had been paid in the first quarter of this FY.

- PMHA office accommodation costs at AMA House in Canberra had been paid in the first quarter of this FY.

- The PMHA's 11 year old recording equipment and associated transcription equipment and software had to be replaced, due to problems with the out dated equipment and software.

- The PMHA annual subscription to the CCH Health and Medical Law Reporter had been paid in the first quarter of this FY. This subscription will not be continued after the end of this FY.

- The provision of support for the ongoing activities of the PMHA's Collaborative Care Models Working Group, including the travel and accommodation costs of its Adelaide–based Consumer Representative and Perth–based Carer Representative and his sitting fees.

- The Perth–based PMHA Deputy Chair attendance at meetings of the Australian Government's Mental Health Standing Committee in the absence of the Adelaide-based PMHA Chair.

The Chair of the Network, Ms Janne McMahon, reported that the additional $5,000 donation from the APS had now been received by the AMA and was not reflected in the AMA Statement of Income and Expenditure, as it was received after 31 December 2011. This placed the Network budget in a better position.

Resolved (unanimous)

1. That the Private Mental Health Alliance (PMHA) adopts the Statement of Income and Expenditure for the PMHA, it's Centralised Data Management Service (CDMS), and the Private Mental Health Consumer Carer Network Australia (Network), for the period 1 July 2010 to 31 December 2011, prepared by the Australian Medical Association (AMA).

2. That the PMHA request that the PMHA Director, the CDMS Director and the Network Chair monitor their respective budgets closely with a view to ensuring the PMHA, CDMS and Network budgets avoid any deficits at the end of the 2011-12 Financial Year.

Action: PMHA Director/CDMS Director/Network Chair

5 PMHA OPERATING GUIDELINES 2011–13

Under the PMHA Work Plan 2011–13, the PMHA is required to review its Operating Guidelines, which served to guide the operations of the PMHA over the past few years. Mr Taylor reported that the Operating Guidelines had been revised in consultation with the AMA Legal Counsel based on the discussions that took place at the last PMHA meeting. The Meeting then considered the final draft of the Guidelines, which had been circulated with the agenda papers. After minor amendment, the Guidelines were endorsed.

Resolved (Unanimous)

That the Private Mental Health Alliance (PMHA) endorses the PMHA Operating Guidelines 2011–13 as amended by the meeting of the PMHA held in Adelaide on 30 March 2012.

Action: PMHA Director

6 PMHA COLLABORATIVE CARE MODELS WORKING GROUP (CCMWG) REPORT

The Meeting adopted the Report of the Eleventh Meeting of the PMHA's CCMWG held on 14 October 2011 in Canberra and noted that the draft Report of the Twelfth Meeting held in Canberra on 17 February 2012. The Chair invited the CCMWG Chair, Mr Taylor, to report on current activities.

6.1 CCMWG Work Program 2012–13

Mr Taylor reported that the focus of the work program for 2012–13 had shifted toward the development of best practice principles for referral and shared care arrangements for private mental health providers for people with complex mental health care needs. Other CCMWG Members present felt this was a very positive development.

Dr Bill Pring felt the presence of Dr Gary Galambos, Chair, Royal Australian and New Zealand College of Psychiatrists (RANZCP or College) Private Practitioner Network (PPN), at the last CCMWG Meeting proved extremely useful given the work the PPN is doing in this area.

The next meeting of the CCMWG will be held on Friday, 18 May 2012 CCMWG in Canberra.

6.2 RANZCP Representation

The RANZCP has reviewed its representation on the CCMWG and confirmed that Dr Richard Astill will continue as the College Representative.

6.3 General Practitioner (GP) Representation

Mr Taylor reported that Mr Tony Cowie from the Royal Australian College of General Practitioners (RACGP or College) has advised that the College is currently sourcing an appropriate GP to participate on the CCMWG. The Meeting discussed the offer to provide a practice allowance for the RACGP representative and agreed that, in principle, it would not be possible to fund such an allowance from the PMHA budget. Mr Taylor was asked to advise the RACGP of this decision. Should this mean that the RACGP is unable to provide a representative for CCMWG, then Dr Pring offered to liaise with the RACGP and the AMA concerning alternative ways of obtaining GP input, particularly for the current work of the CCMWG.

Resolved (unanimous)

That the Private Mental Health Alliance (PMHA) requests that the PMHA Director advise the Royal Australian College of General Practitioners (RACGP) that the PMHA is unable to offer a practice allowance for an RACGP representative to attend meetings of the PMHA Collaborative Care Models Working Group (CCMWG). Should this mean that the RACGP is unable to provide a representative for CCMWG, then Dr Bill Pring is asked to liaise with the RACGP and the AMA concerning alternative ways of obtaining GP input into the current work of the CCMWG.

Action: PMHA Director\Dr Bill Pring

6.4 Guidelines for Determining Benefits for Health Insurance Purposes for Private Mental Health Care 2012 Edition (Guidelines)

The Meeting noted that while the 2012 Edition of the Guidelines had been released informally with the December 2011 Edition of the PMHA Newsletter, they had not yet been promulgated by the Australian Government. Ms Andrea Selleck reported that Health Insurers had identified some confusion is occurring among Health Insurers and

Hospitals as to which version should be used. Mr Taylor was asked to follow this up with Ms Isabel Leal.

Resolved (Unanimous)

That the Private Mental Health Alliance (PMHA) requests that the Private Health Insurance (PHI) Branch of the Australian Government Department of Health and Ageing promulgate Guidelines for Determining Benefits for Health Insurance Purposes for Private Mental Health Care 2012 Edition in the usual way under cover of a Private Health Insurance Circular from the Branch.

Action: PMHA Director\Ms Isabel Leal

7 PMHA QUALITY IMPROVEMENT PROJECT STEERING COMMITTEE REPORT

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 is to make better use of the mechanism of the PMHA and its CDMS. QIP contains a suite of four complementary activities which are being undertaken within the context of the available funding.

1. Implementation of Consumer Perceptions of Care (CPoC) Measure.

2. Outcomes in Private Psychiatry Practice (OPPP).

3. Borderline Personality Disorder (BPD).

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 to strengthen the Work Programs for OPPP and Internet Access to the PMHA's CDMS.

The Meeting then adopted the draft report of the third meeting of the QIPSC held on 20 October 2011 in Adelaide and noted that the fourth meeting was held yesterday in Adelaide back–to–back with this Meeting of PMHA.

Resolved (unanimous)

That the Private Mental Health Alliance (PMHA) adopts the Report of the Third Meeting of the PMHA's Quality Improvement Project (QIP) Steering Committee held on 20 October 2011 in Adelaide

The PMHA noted the last (fourth) meeting of the QIPSC was held on 29 March 2012 in Adelaide and invited the QIPSC Chair, Ms Andrea Selleck, to report on that Meeting.

Ms Selleck reported on some contingencies that have arisen with the QIP, mainly related to the CPoC Work Program.

7.1 QIP CPoC Work Program

This first activity involves the implementation of a standardised measure of CPoC in all private Hospital–based psychiatric services across Australia.

To date, the new *PMHA National Model for the Routine Collection, Analysis and Reporting of Consumer Perceptions of Care by Private Hospital–based Psychiatric Services* (CPoC National Model), has been written and has received favourable review.

However, when the collection of CPoC by private Hospitals with psychiatric beds was first piloted in 2006 the Mental Health Statistics Improvement Program (MHSIP) instruments were considered to be in the public domain. As recently as 2010, research academics still considered this to be the case.[1] In late 2011, however, it was discovered that is no longer the case and the Inpatient Consumer Survey (ICS) of the National Association of State Mental Health Program Directors Research Institute (NRI) Incorporated in the United States of America, is copyright.

Ms Selleck reported that the QIPSC has carefully considered this development in light of the advantages and disadvantages of the following three possible options, which were further elaborated in the discussion paper circulated previously to both the QIPSC and the PMHA.

1. The AMA consider signing a License Agreement with NRI and go ahead with the implementation of the PMHA's modified version of their survey.

2. Abandon the use of the modified versions of the NRI's ICS and the MHSIP Adult Consumer Survey and use the survey being developed for Adult Public Mental Health Services.

3. Go back to the drawing board.

Ms Selleck reported that the QIPSC has endorsed option 3. This will involve reviewing the work done to date, the work being undertaken in the public sector and the work being done by the Australian Commission on Safety and Quality in Healthcare (ACSQHC). In collaboration with the Network's National Committee and the Australian Private Hospitals Association, identify the smallest effective set of items that:

(1) cover the domains identified by ACSQHC as representing best practice internationally;

(2) best meet the needs of private Hospitals; and

1 Royse, D., Thayer, B.A., & Padgett, D.K. (2010). Program evaluation: An introduction (5th Edition). Belmont, CA: Brooks–Cole

(3) most easily allow relevant comparisons with the public sector.

That instrument would then be implemented on a trial basis within the framework already proposed for the National Model and a review would be conducted of its performance after an initial six months of collection and reporting.

QIPSC has supported this approach as it has the following strong advantages.

- It builds on the work already done.
- Both consumers and carers and Hospitals will have had an opportunity to be involved in the further development of the survey(s).
- Hospitals will be able to implement an instrument that is most likely to meet their requirements.
- Hospitals will be able to make effective comparisons with public sector services.
- Problems inherent in options 1 and 2 are avoided.

Ms Selleck explained that Ms Rosenfeld and Mr Morris–Yates will, however, need to redirect some of their time from other work, which will affect the QIP's work programs and also the work program for CDMS, essentially in the following ways.

(1) The QIP CPoC Work Program will now involve the additional development work detailed above, which will delay implementation of the CPoC measure until the first quarter of 2013.

(2) The QIP Outcomes in Private Psychiatry Practice Work Program will not be able to be progressed beyond completion of the major aspect of that program – the Psychiatrists Workload Study. The next phase, which was an analysis of patients with complex needs for care, will not be able to be undertaken. The Private Practitioner Research Network is likely to be able to continue beyond the life of the QIP.

(3) The QIP Internet Access to the CDMS work program will not be affected.

(4) The QIP Borderline Personality Disorder (BPD) work program will not be able to be progressed beyond completion of the original intention to conduct a scoping survey of models of care currently used by private Hospitals for the treatment of people with a diagnosis of BPD. The additional survey of psychiatrists will not be able to proceed.

(5) The CDMS work program will have to be altered to delay the revision of the CDMS's Standard Quarterly Reports. The highest priority now will be for the HSMdb software to be revised, as it is now ten years old.

Mr Morris–Yates then addressed the Meeting in much more detail concerning the revised work plan for QIP which is set out Table 1 below.

Table 1: Revised QIP Work Plan for 2012

Ms Ellie Rosenfeld (ER)			Mr Allen Morris–Yates (AY)
2012	Psychiatrists Work Load Study	CPoC Development	BPD Hospitals Survey
April	ER: Preliminary analysis of responses AY: Retrieve survey data; provide ER with stats support.	ER: Draft paper on items for consultation with APHA PC and PMHCCN AY: advise on above.	ER: Finalise content
May	ER: Brief report of findings for QIP SC and PMHA meetings in June.	ER: Complete paper on items. Consult by teleconference with APHA–PC or their nominees and PMHCCN. AY: as above.	ER: Continue above.
June	ER: Present findings to QIP SC and PMHA. On leave in second half of June.	ER: Consolidate feedback as draft survey for validation testing. Obtain QIP SC and PMHA sign–off on final draft survey for pilot test. AY: As above, and: Implement survey data collection within HSMdb software; Prepare survey formats and administration guide for Hospitals.	
July	ER: Complete analyses, including of written responses and write–up.	ER: Enrol Hospitals in CPoC validation study. (By invitation, based on advice from AY as to which Hospitals can get HSMdb update implemented quickly.) AY: HSMdb update distributed to Hospitals.	ER: Liaise with APHA PC re engagement of Hospitals and advertise forthcoming survey among Hospitals.
August	ER: Complete report of WLS. Submit draft for review by AMA–PG, PPRN and PMHA.	Enrolled Hospitals offer survey and record results	ER: Initiates survey of Hospitals and manages survey process. AY: Loads survey into SurveyMonkey.
September	ER: Collate and integrate feedback from stakeholders.	Enrolled Hospitals continue to collect data.	ER: Undertake analyses of responses and begin drafting report. AY: Retrieve survey data; provide ER with stats support.
October		AY: Retrieve CPoC data from enrolled Hospitals. Complete item analyses and identify final item set.	ER: Complete report of Hospitals BPD Survey. Submit draft for review by APHA–PC, PMHCCN, PPRN and PMHA.
November	ER: Present report to QIP–SC and PMHA for sign–off.	ER: Draft paper describing development and validation of CPoC Surveys for private psychiatric Hospitals. AY: As above and complete report on the CPoC National Model.	ER: Collate and integrate feedback from stakeholders.

At the end of this Agenda Item, Ms Selleck briefly mentioned that the delay with the QIP will have no impact of the QIP budget.

The Meeting also noted that the BPD Survey questions need to be reviewed as QIPSC has agreed that they are worded in a biased and possibly stigmatising fashion.

Resolved (unanimous)

1. *That the Private Mental Health Alliance (PMHA) adopts the revised Work Plan for 2012 for its PMHA Quality Improvement Project (QIP) to accommodate the completion of the QIP Consumer Perceptions of Care (CPoC) Work Program.*

2. *That the PMHA endorses the following being undertaken in relation to the QIP CPoC Work Program to avoid the problems inherent with copyright in using the Inpatient Consumer Survey of the National Association of State Mental Health Program Directors Research Institute Incorporated in the United States of America.*

   2.1 Review the work done to date on the CPoC Work Program in light of the work being undertaken in the public sector and the work being done by the Australian Commission on Safety and Quality in Healthcare (ACSQHC) on consumer perceptions/experiences of care.

   2.2 In collaboration with the National Committee of the Private Mental Health Consumer Carer Network (Australia) and the Australian Private Hospitals Association's Psychiatry Committee, identify the smallest effective set of items that:

      (a) cover the domains identified by ACSQHC as representing best practice internationally;

      (b) best meet the needs of private Hospitals; and

      (c) most easily allow relevant comparisons with the public sector.

   1.3 Implement that instrument on a trial basis within the framework already proposed for the National Model for the Routine Collection, Analysis and Reporting of Consumer Perceptions of Care by Private Hospital–based Psychiatric Services (CPoC National Model).

   1.4 Review the CPoC National Model's performance after an initial six months of collection and reporting.

   1.5 The QIP Research Officer and CDMS Director redirect some of their time from other QIP work programs to complete the revised CPoC work program and implement the measure. The major effect on other work programs will be as follows.

      (a) The QIP Outcomes in Private Psychiatry Practice work program will be considered completed with the publication of the results of the Psychiatrists Workload Study.

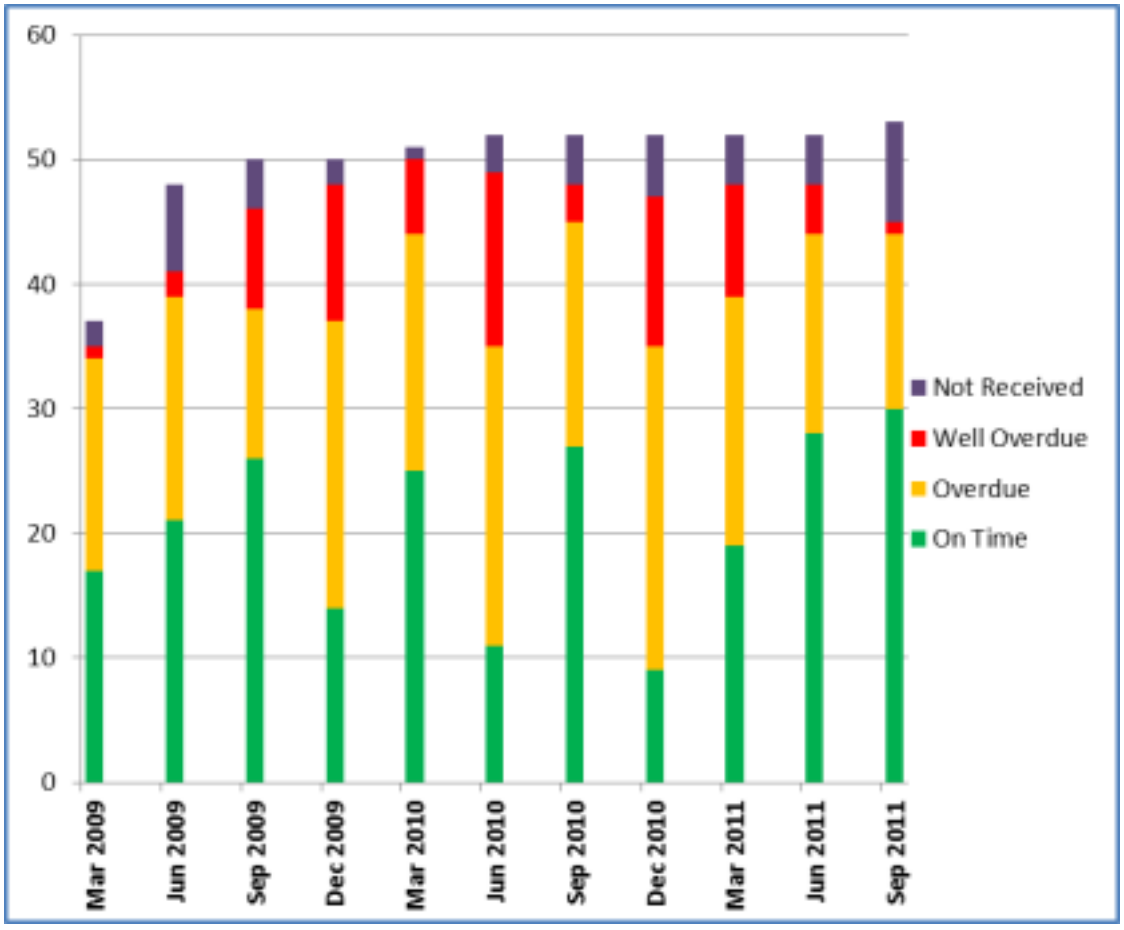
      (b) The QIP Borderline Personality Disorder (BPD) work program will be considered to be completed with the publication of the results of the scoping survey of models of care currently used for the treatment of people with a diagnosis of BPD, who are admitted to private Hospitals with psychiatric beds.

8 PMHA CENTRALISED DATA MANAGEMENT SERVICE (CDMS) REPORT

The Chair invited the Director of the PMHA's CDMS, Mr Morris–Yates, to report on CDMS activity. Mr Morris–Yates reported on the following activities against the CDMS Work Plan.

8.1 Management of data submission by Hospitals and preparation of Standard Quarterly Reports (SQRs)

The most recent submissions of data by participating Hospitals, those for the 1st quarter of the 2011–12 FY (the period ending 30 Sep 2011) were due in by 20 January 2012. Thirty of the 52 currently participating Hospitals were able to get their data in by that date. The CDMS waited for a further two weeks and then began the process of report preparation. The SQRs for Hospitals were despatched on 13 February 2012 and the SQRs for Payers were despatched on 23 February 2012. The following figure illustrates the timeliness of Hospitals' submission of data to the CDMS during the past two years.



The problems with late submissions became so acute that last year the APHA Psychiatric Committee and the PMHA endorsed a change in CDMS policy so that, rather than as had previously been the case, the CDMS no longer waited until all stand–alone psychiatric Hospitals had submitted their data before beginning a report run.

The Meeting noted a copy of the current CDMS memorandum detailing the Submission Schedule. This memo is provided in hard copy format as an attachment to the letter accompanying the SQRs. It has also now been put up on the PMAH website and can be viewed here: http://pmha.com.au/cdms/ImprovingQuality/KeyDocumentsandResources.aspx

Mr Morris–Yates then spoke to the figure below noting that the proportion of Hospitals making late or very late submissions has been steadily decreasing since that change in policy was introduced in the middle of 2011.

The CDMS aims to despatch completed Standard Quarterly Reports (SQRs) to participating Hospitals within 13 weeks of the end of each Quarter. As can be seen in the following table, the CDMS is having significant difficulty in attaining that benchmark. However, with the steady improvement in many Hospitals' capacity to submit their data on time and the implementation of the new policy alluded to above, the timeliness of the despatch of SQRs has begun to improve.

SQRs for the period ending	Date that Hospitals' SQRs were	Date that Payers' SQRs were	Weeks from period end
Mar 2009	20/07/2009	24/07/2009	16
Jun 2009	22/10/2009	29/10/2009	16
Sep 2009	17/03/2010	17/03/2010	24
Dec 2009	18/05/2010	20/05/2010	20
Mar 2010	12/08/2010	12/08/2010	19
Jun 2010	23/12/2010	24/12/2010	25
Sep 2010	06/04/2011	08/04/2011	27
Dec 2010	19/05/2011	20/05/2011	20
Mar 2011	25/08/2011	26/08/2011	21
Jun 2011	13/10/2011	24/10/2011	15
Sep 2011	13/02/2012	23/02/2012	19

Ms Munro felt that Hospitals should be congratulated for what they are achieving.

8.2 Maintenance of infrastructure

The Meeting noted that following the decision to re–locate the primary CDMS computing infrastructure to a data centre in the Adelaide CBD, two second–hand servers were purchased and configured as the primary domain controller and mail server (a Dell PE 1950 II) and virtual machine host under which the interface to the data warehouse is run (a Del PE 2950 III). Both those machines are scheduled to be replaced. In December 2011 a replacement was purchased. This consists of a single server (a Dell PE R610) with a direct attached storage array (a Dell MD 3200). As well as hosting all the functions currently performed by the existing two servers, this machine and its associated storage array will also serve as the primary backup and archive repository for both the data warehouse running under pmha–cdms.com.au and the websites running under pmha.com.au.

Configuring this new server and then transferring the domain control and mail functionality from the existing server is a significant task. Over the 2011 Christmas

break a similar task was completed at the Dale Road offices of Yates Systematics Pty Ltd, with the full completion of all work associated with the transfer taking approximately 8 days. The transfer itself is a complex process that is not automated and which requires careful attention to the completion of a sequence of tasks in a specific order, with a strong likelihood that problems requiring the completion of additional tasks may be encountered at certain points in the process.

Several significant issues need to be managed in the transfer.

First, whilst some of the initial configuration of the new machine can be done in the workshop at Dale Road, completing the actual transfer of functionality from the old to the new server requires that both the old machine and the new machine must be directly connected during that process. Accommodating both the old and new server in the rack will require removing the other 2950 from the rack, meaning that the data warehouse will not be accessible during the transfer phase.

Second, the transfer of mail server functions will likely result in some interruption to both the CDMS Director's and QIP Research Officer's mail service. Previous experience indicates that the outages should not last longer than a few hours.

Third, because the domain controller manages remote access to the server infrastructure and the domain controller will need to frequently re–booted during the transfer process, much of the work will need to be completed on–site at the data centre, rather than remotely. This means that the CDMS Director will not have ready access to the Dale Road office's workshop facilities, reference library or internet services.

Given all the above, the replacement of the old servers will be undertaken in April, well after the QIP Psychiatrists Workload Survey has been completed.

8.3 Ongoing development of CDMS Data Warehouse (CDMSdwh)

8.3.1 Changes in the reporting of data collection statistics for Ambulatory Care

Significant changes have been to the way in which the CDMS reports data collection statistics for Ambulatory Care. Many Hospitals appear to have some difficulty in reliably collecting outcome measures within the Ambulatory Care service setting. The level of detail reported about that has now been substantially increased in the SQRs to help Hospitals better pinpoint where they are falling down in their collection. These changes affect two tables and one figure in the report.

First, a new table, identified in the reports as Table 1.4, has been added. This table identifies what proportion of the expected collection occasions (Admissions, Reviews or Discharges) were actually recorded by the Hospital. During the processing of the submitted data, the HCP episode records representing occasions of service in Ambulatory Care are examined and assigned to episodes of care on the basis of the definition of such episodes under the National Model. Given that, any missing collection occasions are then identified. This enables statistics regarding service utilisation and outcomes in episodes of Ambulatory Care to be accurately calculated. Table 1.4 reports on the results of the imputation process.

Table 1.4: Imputation of missing Collection Occasions in Ambulatory Care during the current Quarter and the current 12 Months.

	Admission	Review	Discharge	Overall
This Hospital in current Quarter				
Records actually reported in submitted data	42	7	42	91
Estimate of the Total number of Collection Occasions that should have been collected	158	106	60	324
Proportion of records estimated as required that were actually submitted	27%	7%	70%	28%
This Hospital in current 12 Months				
Records actually reported in submitted data	155	16	151	322
Estimate of the Total number of Collection Occasions that should have been collected	465	116	367	948
Proportion of records estimated as required that were actually submitted	33%	14%	41%	34%

Second, the existing table reporting on the completeness of HoNOS and MHQ–14 collection has been modified so that it is based on the actual data submitted, without including any additional Admissions, Reviews or Discharges that may have been imputed in the process described above.

An example of that revised table, Table 1.6, is shown below.

Table 1.6: Data collection statistics for Collection Occasions recorded in Ambulatory Care during the current Quarter and the current 12 Months.

	Collection Occasions	Completed HoNOS A	Completed HoNOS R	Completed HoNOS D	Completed MHQ-14 A	Completed MHQ-14 R	Completed MHQ-14 D	Overall Rate
This Hospital in current Quarter	91	57%	71%	50%	74%	71%	52%	59%
This Hospital in current 12 Months	322	54%	56%	40%	63%	63%	38%	50%
All Hospitals in current Quarter		80%	93%	68%	71%	79%	46%	75%
All Hospitals in current 12 Months		80%	92%	68%	74%	78%	50%	74%
Top 5 Hospitals in current Quarter		93%	75%	86%	87%	66%	76%	83%
Top 5 Hospitals in current 12 Months		97%	98%	96%	95%	90%	88%	95%

The principal reason for presenting the data in this new way is to help Hospitals understand exactly where in their data collection process the expected HoNOS and MHQ–14 are being missed. For instance, comparing the results in Tables 1.4 and 1.6 allows us, in this example, to note that even when Admissions are recorded, the HoNOS completion rate is still well below that expected.

Mr Morris-Yates reported that this work has delayed the provision of the CDMS Annual Statistical Report.

8.3.2 SQR for Hospital Groups

The CDMS recently completed a new SQR summary for Hospital Groups. This new report is based on statistics contained in the SQRs provided to participating Hospitals.

It presents key statistics for each Hospital within the group in a format that is designed to facilitate comparison of those statistics. The report is formatted as a presentation in landscape orientation designed to be viewed by a number of people sitting around a data projector rather than as a detailed statistical report intended to be read closely by a single individual. Key statistics are presented in both numerical and graphical formats.

A de–identified and completely fabricated (i.e., assembled from a random selection of Hospitals) example of the report was demonstrated for the Meeting. This report will be distributed to nominated key staff members of the following Hospital Groups:

- Healthe Australia Pty Ltd (4 Hospitals)
- Healthscope Ltd (13 Hospitals)
- Independent Private Hospitals of Australia (2 Hospitals)
- Ramsay Healthcare (16 Hospitals)
- St John of God Health Care Inc (4 Hospitals)

Together, the Hospitals belonging to those Hospital groups, account for 39 of the 52 Hospitals currently participating in the PMHA and its CDMS.

The Meeting noted that providing such reports for Hospitals Groups would require the CDMS Director to receive a signed release specifying the period that is covered. Such benchmarking reports will not provide information about charges stratified by Health Insurer.

Ms Helen Eriksson requested more time for Health Insurers to consider this proposal in relation to a couple of perspectives.

- Firstly, something different is now being done with the CDMS data in response to a request form Hospitals that Health Insurers would also like to understand.

- Secondly, whether it may be possible to do similar benchmarking for Health Insurer's and their Member populations.

Mr Morris–Yates indicated that, while the CDMS would be able to provide similar information, Health Insurers would have to first investigate whether there are any legal implications with such benchmarking.

Mr Morris–Yates explained that providing corporate aggregate statistics to Health Insurers at the group level is one of the revisions documented in the Revised Reporting Framework for the SQRs. This implementation of the Framework for Health Insurers has been delayed by the contingencies of the QIP's CPoC Work Program. If Health Insurers wanted aggregate statistics at any other kind of group level that aggregated specific Hospitals together, that were not part of a corporate ownership group, then those Hospitals would individually have to give their permission for the CDMS to do that.

Mr Morris–Yates explained that what will be provided to Hospital benchmarking corporate groups is a report that is based not on any reconfiguration of the analysis component of the CDMS Data Warehouse. Rather, what is proposed is a very

minimal change of what has already been developed for the Hospital corporate groups, whereby Hospitals can, through a written agreement, become members of a Hospital benchmarking group. The CDMS Director would have to receive a signed release from the Hospital benchmarking group that specifies the period covered.

8.4 Redevelopment of HSMdb

The current version of HSMdb, Version 1–82, is an MS Access 97 application. That version of MS Access is no longer supported by Microsoft. The current version of HSMdb also makes use of certain operating system features that are becoming increasingly problematic to use in the latest versions of MS Windows (particularly Windows 7 and Windows Server 2008 R2). In the second half of last year Mr Morris–Yates began work on the redevelopment of the application in MS Access 2010. This is a major upgrade and, due to certain very significant differences in the two versions of the MS Access software, affects many aspects of HSMdb. Its initial release will be referred to as HSMdb Version 2–0.

At the Hospital level the process of updating the software to version 2–0 will not be as straightforward as usual. Based on previous experience with some Hospitals groups, it is not expected that all Hospitals will be in a position to implement the major update this year. Consequently, a minor update of the existing Access 97 based version of HSMdb (to version 1–83) will also be made available to participating Hospitals. The expectation is that all Hospitals using HSMdb will have upgraded to version 2–0 by the second half of 2013.

8.6 Other Work undertaken by the CDMS

Other work undertaken by the CDMS since the last PMHA meeting in October 2011 has principally focussed on the QIP and is covered in the report on those projects under Agenda Item 7 above.

9. 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.

9.1 PMHA Newsletter

Mr Taylor reported that the Tenth (Christmas) Edition of the PMHA Newsletter was released in December 2011.

The Meeting then considered a copy of the draft Eleventh Edition, due for publication in April 2012, which had been circulated with the agenda and papers. After minor amendment the Meeting approved the Newsletter. Ms Milthorpe will review the article on the Ten Year Road Map and provide any amendments or alternate material.

Resolved (unanimous)

That the Private Mental Health Alliance (PMHA) requests that the PMHA Director coordinate the release of the Eleventh Edition of the PMHA Newsletter, via email, in April after completion of the Fact Sheet.

Action: PMHA Director

It was agreed that the next (Twelfth) Edition of the PMHA Newsletter should be devoted to the PMHA QIP.

10 PRIVATE MENTAL HEALTH CONSUMER CARER NETWORK (AUSTRALIA) [NETWORK] REPORT

The Meeting noted the draft report of the last meeting of the Network's National Committee (NC) held on 27/28 February 2012 in Melbourne. The next meeting of the Network's National Committee will be held in Adelaide on 6/7 October 2012 to coincide with the BPD Awareness Day Conference, scheduled for Friday 5 October 2012.

The Chair then invited the Chair of the Network, Ms Janne McMahon, to report on the Network activities. Ms McMahon reported on the following.

10.1 Network Work Plan

The Network Work Plan for 2011–13 has been revised to fully document the current position and intended activities for each objective under a new column titled, *Status*. PMHA Members noted that a copy of the revised Work Plan had been circulated as additional information for this Agenda Item. The PMHA agreed with the revised Work Plan the Meeting confirmed that they had no comments or queries regarding the revised Work Plan.

10.2 Network Operational and Policy Documents

The Network's Operating Guidelines have been revised in view of the changes that have been made to the role of the Executive Officers of the Network to enable the PMHA to meets its obligations to the AMA under the *AMA Agreement for Services 2011–2013*. The Network's National Committee is also reviewing its policy documents and there are several new policies under development.

10.3 Borderline Personality Disorder (BPD) Consumer and Carer Survey and Reports

In 2010, the Commonwealth established a BPD Expert Reference Group (BPDERG) to advise the Minister Butler, on ways to better identify, treat and manage people with BPD. BPDERG includes clinicians, researchers, carers and consumers (including Ms McMahon) all with extensive knowledge of BPD.

BPDERG is gathering information from public and private sector on policies and treatment options for people with BPD and their carers. As part of that work, the BPDERG asked its Carer representative, Eileen McDonald and Ms McMahon to gather information from consumers and carers via a survey to help inform their discussions. Ms McMahon developed a BPD Consumer Survey and a BPD Carer Survey in consultation with prominent consumers and carers. Associate Professor Sharon Lawn undertook the analysis of these surveys, which were conducted online during June 2011 under the auspice of the Network.

Since the last meeting of the PMHA, the following has been undertaken in relation to the draft reports on the survey results.

10.3.1 BPD Consumer and Carer Summary Report

At the end of 2011, a team of researchers comprising Professor Andrew Page, Mr Allen Morris–Yates, Ms Ellie Rosenfeld and Associate Professor Sharon Lawn worked with Ms McMahon to complete the Summary Report. The PMHA subsequently reviewed and endorsed the Report as suitable for submission to the BPDERG. The Report was submitted to the BPDERG on 17 January 2012. The Summary Report was very well received.

10.3.2 BPD Primary Reports

In their present form the other two Primary Reports are not ready for release and will require some further work. Reference to the two primary reports has therefore been omitted from the Summary Report. Once the two Primary Reports have been revised and signed off by the PMHA, then the Summary Report will most likely also need some revision. At that point, the references to the two Primary Reports can be put back into the Summary Report. Ms McMahon reported that this matter had been raised at the meeting of the BPDERG held on 9 March 2012. The BPDERG supported Ms McMahon's subsequent approach to the DoHA to have this additional work undertaken. DoHA has asked for information on what this additional work would entail and Ms McMahon has discussed this request with Mr Morris–Yates. Ms McMahon will be preparing a funding submission for DoHA for this additional work in consultation with Mr Morris-Yates. If the funding submission is successful, whoever is commissioned to undertake the additional work will be advised to contact Mr Morris-Yates to further discuss what is involved with the additional work.

10.3.3 BPD Informal Contact Group

Since the last PMHA Meeting, the 87 members of the BPD Informal Contact Group were advised there were difficulties with the Network's auspicing arrangements and that the Informal Group would need to be dissolved. They were then invited to become members of the Network. The 10 who responded have been included on the Network Members database held by the Federal AMA in Canberra. The list of email addresses held by the Network Chair in Adelaide has been securely erased. Ms McMahon felt that this situation could have been avoided if the Network's Risk Management Strategy had been reviewed with subsequent endorsement by the PMHA.

10.4 BPD Awareness Day and Conference

In 2011, 5 October was declared National BPD Awareness Day. The last meeting of the PMHA had no objection to the National BPD Awareness Day Conference being held in Adelaide on Friday, 5 October 2012, provided Network core funding was not used for this event. On that basis, Ms McMahon submitted an application to the Mental Health Council of Australia (MHCA) for it to fund the Conference from its MHCA grant program, with the grant monies being held by the AMA. If the application is successful the next meeting of the NC will be held in Adelaide on 6/7 October 2012 at the Chair's home office to enable NC Members to participate in the Conference. NC Members participation at the Conference will be on a voluntary basis. Information will be distributed about six weeks in advance of the Conference. Ms McMahon invited the PMHA to include a speaker in the Conference program. After discussion, it was agreed that Members would consider this invitation out–of–

session and advise Mr Taylor by the end of April as to whom the speaker at a Conference would be.

Resolved (unanimous)

That the Private Mental Health Alliance (PMHA) requests that Members consult their constituencies and advise the PMHA Director by 30 April 2012, of any PMHA speakers they might wish to have included in the program for the National Borderline Personality Disorder (BPD) Awareness Day Conference to be held in Adelaide on Friday, 5 October 2012.

Action: PMHA Members/PMHA Director

10.5 Network National Committee Member activities

Ms McMahon briefly mentioned some of the activities that the other members of the Network's National Committee are involved in which include the following.

- Redevelopment of GP Mental Health Care Plans and GP education
- Insurance Reform
- Pharmacy Guild of Australia's training package for pharmacists on mental health
- E–Portal for consumers to get information and possibly treatment, or referral for treatment, via the internet
- Training for health professionals including GPs.
- Mental Health Nurse Incentive Program.

The Meeting noted that Mr Partick Hardwick is assisting Ms McMahon with sourcing an appropriate Network Coodinator for New South Wales to replace Mr Lee Hill who has resigned from this position. Mr Hardwick is also involved in range of other national bodies which provides an opportunity to promote the Network and the PMHA.

10.6 Network Policy 8: Carer Support

The Meeting discussed some of the wording of the Network's draft Carer Support policy which reads:

> *The role, adequacy of information, education, and support for primary carers in private sector settings is not currently valued to the extent it should be.*
>
> *Hospitals providing this type of program do so at their own expense.*

Health Insurers reported that the funding they provide for Hospitals is for episodes of care which they expect, where appropriate, are inclusive of a consumer's primary carer. Hospitals indicated that, while this is the case, programs that are specifically

directed at bringing together and supporting carers do not fall within that funding context and are therefore provided by Hospitals at their own expense.

After discussion, the Meeting agreed this is a grey area and suggested that the Policy should be reworded to acknowledge that there is some controversy around this issue, which remains unresolved.

10.7 Cries for Help

Ms McMahon and Mr Taylor reported "in committee" on some recent appeals for help that had been received and the actions taken to follow–up. The Meeting agreed that an incident register should be established to document such incidents and actions taken.

Resolved (unanimous)

That the Private Mental Health Alliance (PMHA) requests that an Incident Register be established to formally record any cries for help that might be received and the follow–up actions taken.

Action: PMHA Director

11 MENTAL HEALTH STANDING COMMITTEE (MHSC) REPORT

The MHSC reports to the Australian Health Ministers' Conference (AHMC) through the Australian Health Ministers' Advisory Council (AHMAC) and the Health Policy Priorities Principal Committee (HPPPC). The PMHA is represented on the MHSC by the PMHA Chair, Mr Phillip Plummer, and the PMHA Deputy Chair, Ms Moira Munro. The Meeting noted a copy of the draft minutes of the 24 November 2011 MHSC. The last meeting of the MHSC was held in Brisbane on 17 February 2012. Ms Moira Munro attended both of these meetings and reported on the following.

11.1 Review of AHMAC Committee Structure

AHMAC has accepted the final report and recommendations of the Review of the AHMAC Principal Committee and governance structures. The new Principal Committee structure comprises the following.

1. Australian Health Protection Principle Committee (AHPPC)
2. Community Care and Population Health Principal Committee (CCPHPC)
3. Health Workforce Principal Committee (HWPC)
4. Hospitals Principal Committee (HPC)
5. Mental Health/Drug and Alcohol Principal Committee (MHDAPC)
6. National Health Information and Performance Principal Committee (NHIPPC)

The Health Policy Priorities Principal Committee (HPPPC) is to be disbanded and its work transferred to other Principal Committees, primarily the CCPHPC.

The MHDAPC will now undertake the following.

- Work previously undertaken via the MHSC.

- Work undertaken through the Fourth National Mental Health Plan Cross Sectoral Working Group (CSWG).

- The responsibilities of the Intergovernmental Committee on Drugs (IGCD) which, as one of its responsibilities, has the ongoing work of the National Drug Strategy 2010–15.

Dr Peggy Brown has been appointed as Chair of the MHDAPC. It is envisaged that MHSC will report to the MHDAPC. MHSC has discussed the potential implications for MHSC and its subcommittees in terms of role and membership. HPPPC is next due to meet on 3 April 2012 and business continues to be progressed for hand over to the relevant Principal Committees.

11.2 MHSC Chair and Executive

At its meeting on 22 November 2011, the HPPPC appointed Mr David McGrath as Chair of MHSC. MHSC subsequently undertook a nomination and election process for the resultant vacancies on the MHSC Executive due to the appointment of Mr McGrath and the departure of Dr John Crawshaw, the Tasmanian representative on the MHSC who was also on the Executive as a jurisdictional member. The new Executive comprises:

Chair	Mr David McGrath
Deputy Chair	Mr Derek Wright (SA Representative)
Jurisdictional Members	Mr Alan Singh (Commonwealth DoHA Representative)
	Ms Bronwyn Hendry (NT Representative)
	Mr Richard Bromhead (ACT Representative)

11.3 Independent Hospital Pricing Authority and Activity Based Funding

Dr Tony Sherbon, Acting Chief Executive of the Independent Hospital Pricing Authority (IHPA) attended the 17 February 2012 MHSC meeting and spoke about the IHPA and the Activity Based Funding (ABF), which for mental health will come into effect from 1 July 2013. Specific areas of MHSC interest relate to where mental health sits in relation to ABF, the potential risks and any information, or issues that the IHPA may want to raise.

Dr Sherbon provided a brief background to the formation of IHPA and the agreement to establish ABF as the *primary* vehicle of Hospital funding. A basic ABF exists at the moment and, while not ideal, for the first year the current inpatient system will be applied. The IPHA intends to invite stakeholder representatives including the MHCA, the MHC and MHSC to work with IPHA during the second half of 2012 to review the current mental health classification system.

Ms Milthorpe mentioned that submissions that have been made to the IPHA are available from the IHPA website at: http://www.ihpa.gov.au

11.4 Farewell for Dr Aaron Groves

The PMHA noted that Ms Munro had attended the MHSC farewell for Dr Aaron Groves, which was held on the evening of 16 February 2012 in Brisbane. Ms Munro

took this opportunity to thank Dr Groves on behalf of the PMHA for his highly inclusive support of the private sector and the work of the PMHA and its CDMS.

11.5 MHSC meetings in 2012

The next MHSC meeting is scheduled for Friday, 11 May 2012 in Sydney and the final meeting for 2012 is scheduled for 26 October in Melbourne.

12 MHSC SQPS REPORT

The SQPS is responsible for taking the Australian Government mental health safety and quality agenda forward. The PMHA Representative on the SQPS, Dr Bill Pring, reported that the last SQPS meeting was held on 9 March 2012 in Sydney and the next meeting is scheduled for 13 July 2012 in Melbourne. A copy of the draft minutes of the 18 November 2011 meeting and the agenda for the 9 March 2012 were noted. Dr Pring then updated the PMHA on the following SQPS activity.

12.1 Mental Health National Outcomes and Casemix Collection (NOCC) Review

SQPS and the Mental Health Information Strategy Subcommittee (MHISS) are both involved in this Review.

The Meeting noted that NOCC was first specified in August 2002, and implemented progressively by states and territories in the years that followed. This process followed a commitment made three years earlier (1999) by states and territories under the Second National Mental Health Plan, to introduce the routine collection of outcome and casemix data in public mental health services.

MHISS endorsed the undertaking of a review of NOCC to be completed in the period of the Fourth National Mental Health Plan (2009–14), to set directions for the next stage of development over the next 10 year period. MHISS referred the review to the National Mental Health Information Development Expert Advisory Panel (NMHIDEAP). Over recent meetings, the NMHIDEAP has held a number of discussions about how best to progress the review of NOCC. The NMHIDEAP has produced a project plan for the review, called the NOCC Strategic Directions 2014 – 2024, which outlines a two year review process that includes a stocktake of progress. The project plan was endorsed by MHISS in November 2011 and MHISS recommended that NMHIDEAP continue to oversee and steer the review of NOCC.

Dr Pring reported on the uninformed criticisms that appear to be arising from this review over the use of the Health of Nation Outcomes Scale (HoNOS) outcome measure, which is being used in both the public and the private sector. Mr Morris–Yates briefed the Meeting on the history and usefulness of HoNOS, particularly in relation to the private sector where it has been well accepted by Hospitals, clinicians and consumers as a robust measure for routine reporting of clinical status since 2001. There will be a two day workshop in Melbourne of consumers and carers on the NOCC that Mr Hardwick will be attending.

12.2 Medication Safety – National Inpatient Medication Chart (NIMC) in psychiatric facilities

The PMHA discussed developments with the ACSQHC and the difficulties being encountered with the development of a National Inpatient Medication Chart (NIMC). The Meeting noted that on 12 September 2011, the ACSQHC distributed the psychiatric NIMC online survey to health professionals and managers working in psychiatric acute care services through jurisdictional contacts and the Society of Hospital Pharmacists of Australia member networks. The main purpose of the psychiatric NIMC survey was to seek information on use of the NIMC in acute psychiatric services; and views on its benefits and other attributes. Key findings included the following.

- Support for the NIMC in acute psychiatric services with explicit support for the benefits of standardised charting across whole facilities.
- High level of concern about the capacity of the NIMC in relation to clozapine.
- Concerning level of non–standard NIMC use with safety implications.

A number of recommendations have arisen from the report, which are being considered by the Health Services Medication Expert Advisory Group.

Ms Munro reported that ACSQHC has been advised that NIMC does not suit private sector facilities. Ms Chistine Gee is on the ACSQHC and hopefully this situation will be able to be resolved. If not, then it is likely an adaptive form of NIMC will be used by private Hospitals.

Dr Pring reported that work of the ACSQHC will go beyond the work on NIMC to a medication safety self–assessment tool, which is likely to have implications for Hospitals.

12.5 Developing a Recovery Framework

Progression to a National Recovery Framework as per the Fourth National Mental Health Plan will assist in facilitating a culture and commitment to recovery orientated practice. DoHA has provided funding to conduct a consultation process to develop a National Recovery Framework. A working party has been formed and Craze Lateral Solutions is conducting the consultation process to develop a draft Framework to take to a Recovery Forum, which will be held in Melbourne on 21\22 June 2012. The PMHA will be invited to attend the Forum.

12.4 National Standards for Mental Health Services

The implementation of the National Safety and Quality Health Service Standards developed by the ACSQHC will impact on the work to implement the National Standards for Mental Health Services. The Commission conducted a preliminary mapping exercise to identify the overlap of the National Safety and Quality Health Service Standards and the National Standards for Mental Health Services. That exercise identified an approximate intersection of 40% between both sets of

Standards. SQPS considered that an approach to reduce the overlap for services implementing both Standards would require further consideration.

At the November 2011 meeting, SQPS agreed to consideration of a further workshop with accreditation providers and the ACSQHC. This was referred to the 30 November meeting of the National Standards Implementation Advisory Committee for their advice. The Chair and the Department held a face–to–face workshop with ACSQHC staff to review and continue the mapping exercise and to discuss how to address the dual accreditation issues facing the mental health specialist service sector. ACSQHC subsequently completed the additional revisions to the mapping exercise and presented some options for accreditation at a workshop for State and Territory Directors of Mental Health, accreditation agencies, SQPS members and consumer and carer surveyors on 8 March in Sydney. Ms Carol Turnbull attended the Forum for the PMHA.

12.6 Seclusion and Restraint Forum

Preliminary planning for the 8th National Seclusion and Restraint Forum has begun under the auspice of Queensland Health. The Forum will be held in Cairns on 29 and 30 October 2012. Webcasting will be included to allow maximum participation. The 2011 Forum included a presentation on data elements and the intention is for this to be a regular session at future forums.

12.7 ECT Safety

SQPS has recognised there is potentially a limited role for them in relation to general oversight and also in relation to quality and safety practice, standards and audit processes to drive quality assurance. Jurisdictional members agreed to contribute to a broad stocktake on ECT. Dr Davidson (WA) agreed to facilitate that activity which could include information on guidelines/protocols, regulations, inclusion in legislation, review processes and best practice guidelines. Ms Milthorpe indicated that this work is intended to summarise what to expect within each jurisdiction. Dr Pring offered to provide commentary on the private sector.

12.8 SQPS Meetings for 2012

The SQPS meeting schedule for 2012 is set out below.

- 9 March 2011 Sydney
- 13 July 2011 Melbourne
- 16 November 2011 Melbourne

13 MHSC MENTAL HEALTH INFORMATION STRATEGY SUB–COMMITTEE (MHISS)

MHISS provides expert technical advice and recommendations on initiatives to address the information requirements for MHSC. The PMHA Representative on the MHISS, Ms Moira Munro, reported that the last two MHISS meetings were held on 3/4 November 2012 in Sydney and 15/16 March 2012 in Melbourne. A copy of the minutes of November 2011 and the agenda for the March 2012 were noted. Ms Munro reported on the following.

13.1 Mental Health Non–Government Organisation National Minimum Data Set Project

In February 2011, the Australian Institute of Health and Welfare (AIHW) commenced Phase 1 of the Mental Health Non–Government Organisation (NGO) National Minimum Data Set (NMDS) Project. The Project's aim is to collect nationally consistent information on the mental health NGO sector. Data from the proposed NMDS would better inform policy, practice and planning of national mental health NGO activities to support people living with a mental illness, including their carers and families.

Throughout 2011, AIHW entered into a partnership with Community Mental Health Australia (CMHA), established a mental health NGO NMDS Project Reference Group, and held a national consultation workshop with a range of sector stakeholders to discuss the information needs of the mental health NGO sector. A final report with three recommendations was tabled to MHISS at the November 2011 meeting. MHISS agreed to proceed with the development of an input and output establishment level mental health NGO data collection for potential implementation from the 2013–14 reporting period and a number of proposed refinements were suggested by DoHA. MHISS does not have the capacity to develop local client information systems, but can influence their development through establishing an NMDS, the setting of national specifications and standards, and the supporting infrastructure that will be required. It is hoped that the development of a mental health NGO establishment level collection will be the first step in influencing this process.

The Working Group met in Sydney on 1 February and again on 29 February to consider the interface between the NGO service type categories drafted for the NGO NMDS and those drafted for another Commonwealth project to develop a National Service Planning Framework.

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

This project will investigate the development of a tool for measuring carers' experiences and perceptions of mental health services within a recovery framework, to give effect to the commitments in the Fourth Plan. The Carer representative on MHISS, together with the Australian Mental Health Outcomes and Classification Network (AMHOCN) and a small working party undertook a literature review to inform the selection of an existing, or if required, development of a new, draft instrument. The literature review found that one measure, the Consumer and Carer Experiences Questionnaires (CCEQ), may be suitable for further development as a standard measure of carers' experiences of service provision across Australia.

At the November 2011 MHISS meeting, Members considered the findings of the literature review and agreed a proposal should come back to the March 2012 meeting for modifying and piloting the CCEQ. MHISS agreed that the carer measure be developed with the principal purpose of being useful for service quality improvement. Additionally, it was recommended that further development of the measure should be targeted at building an instrument that is primarily used for periodic survey sampling rather than routine day–to–day use. Work is currently underway in conjunction with AMHOCN to finalise the project plan to bring back to MHISS so that work can

proceed to modify and enhance the CCEQ instrument and undertake cognitive testing during the next six months.

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

AMHOCN has been commissioned by MHISS to develop a consumer self–report measure that provides information on social inclusion outcomes such as education, employment and housing for youth and adults. In response, AMHOCN has developed a measure called the *Life in the Community Questionnaire* (LCQ) and undertaken a proof of concept pilot. The pilot saw a small number of services using the LCQ as part of clinical practice. The views of consumers and clinicians who used the tool were gathered online and in focus groups. AMHOCN also undertook an online survey with consumers, carers and clinicians and presented the LCQ at TheMHS Conference. AMHOCN presented a report on the results of the proof of concept pilot to the November 2011 MHISS meeting. The results of the pilot were promising but indicated the need for additional work on the LCQ to create a measure that not only enabled reporting of the five agreed indicators but also produced high quality information. MHISS has requested AMHOCN continue to further develop the measure before considering larger field trials. The initial goal of this further work should be to develop a measure suitable for inclusion in routine outcome measurement protocols and which supports engagement, dialogue and clinical practice.

13.4 Measuring Consumers' Experiences of Care

The Victorian Department of Health, with the support of the Commonwealth, is leading a project to develop a measure of consumers' experiences of care to give effect to the commitments in the Fourth National Mental Health Plan to strengthen the focus of the mental health sector on consumers' experiences of care. The Expert Advisory Group guiding the project met for the third time on 16 February 2012. Mr Morris–Yates attends meetings of this Group as a proxy for Ms Munro. Mr Morris–Yates reported that the Victorian Department of Health, through a consultancy with IPSOS, has finalised a literature review and a national consultation with jurisdictions, health services, consumer peaks and other experts and stakeholders to explore options for a national measure. The proof of concept trial portion of the project is being expanded to increase the number of sites and consumers targeted to test the consumer experiences of care instrument. Consumer consultants and proof of concept sites have been recruited and training will be provided once ethics approval has been obtained. The proof of concept trial is expected to commence in June 2012.

13.5 Mental Health Intervention Classification (MHIC)

The development of a Mental Health Intervention Classification (MHIC) system has been an iterative process. The current version, MHIC 09, is a multi–axial intervention scheme designed to capture 'selected' mental health interventions. The MHIC 09 was also developed to be provider neutral and provide a pragmatic system for routine data collection.

The AIHW was contracted by DoHA to develop, implement and conduct a pilot study of the prototype MHIC 09. The pilot study provided the opportunity for operational and 'real–world' testing of the MHIC 09 to determine whether it is a valid, effective

and practicable tool for use within the Australian mental health–care context. Following feedback received as a part of the MHIC 09 pilot study (undertaken between May and July 2011) the AIHW has undertaken further refinements of the scheme to produce a version of MHIC 09 suitable for implementation. These refinements are as follows.

- Improving the guidelines through more detailed descriptions of the individual interventions.
- Including additional codes and/or new groups for case conferencing/liaison interventions, to meet the needs of the CAMHS setting.
- Adding a generic 'Other intervention not elsewhere specified' code for highly specialised interventions. Alternatively, develop specific codes for interventions provided by specialised segments of the workforce, for example occupational therapists.
- Creating strong business rules for data reporting when more than one client and/or clinician is present during the intervention.
- Creating a 'volume' aspect to the MHIC codes for interventions provided to admitted patients, to cover the possibility of one or more of the same intervention being provided during a single separation. Note that this type of coding concept currently exists for the ACHI coding of ECT.
- Including more detailed codes for pharmacotherapy prescription to glean additional information on dosage, whether the prescription is a new or ongoing treatment, and whether the prescription is a one–off or repeat.

13.5.1 MHIC Implementation

There are a number of options for implementing the collection of MHIC data from the various mental health data collections. However, a gradual phased implementation plan for the MHIC could be achieved utilising an 'opt–in' approach, with jurisdictions deciding when to begin collecting and reporting information on mental health interventions via MHIC 09. It would be reasonable to expect that those data collections which are within the control of MHISS members, such as the Community Mental Health Care (CMHC) and Residential Mental Health Care (RMHC), could have MHIC introduced within the next 2–5 years. Subsequently, national collection and reporting of mental health intervention information, via the CMHC and RMHC NMDSs, could be achieved once all jurisdictions had implemented and were collecting mental health intervention information via MHIC 09.

In terms of admitted patient data collections, it is likely that the incorporation of MHIC into these would require a longer lead–time for implementation. In addition, further consultation and negotiation with private sector providers would be expected.

The need to include a 'volume aspect' to enable the numbers of times a particular intervention is administered to a patient during an episode of admitted patient care has previously been identified. It is proposed that any volume aspect for interventions

delivered during admitted patient care would use the same format as that proposed for ECT.

As such, the draft report presents a section which discusses 'next step'. It is proposed that this section will be finalised following agreement and endorsement by MHISS on the approach to be recommended for implementing MHIC 09.

3.5.2 Pathways to a National Standard

The AIHW proposes that, following endorsement by MHISS, that MHIC 09 be included as a national standard in METeOR.

The rationale for taking this this approach is based on the AIHW's view that it is likely that the MHIC scheme will be implemented in non–admitted patient mental health data collections first as part of a phased implementation. This view is based on the technical and workforce issues which were identified by clinical coders during the pilot phase of MHIC 09.

If the MHIC 09 were to be implemented for admitted patient data collections, it is proposed that a separate project to undertake the integration of MHIC codes into the ACHI be undertaken at that time.

13.5.3 Next Steps

Following agreement and endorsement by MHISS, it is proposed that the AIHW will contact the ABF Mental Health Advisory Working Group and the National Casemix and Classification Centre to inform them of the development of the MHIC, provide them with a copy of the final MHIC 09 report and MHISS's proposed approach to implementation.

13.6 Next Meeting

The next MHISS Meeting will be held on 7/8 June in Darwin

14 OTHER BUSINESS

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

14.1 Private Patients in Public Facilities

Mr Taylor reported that at least one private Hospital CEO has reported getting transfers from the local public hospital of patients that have been treated privately sometimes for weeks on end. The first the private Hospital knows about it is when they do a health insurer check only to find the patient is in stepdown as a result of their public inpatient stay. There has been a few cases where this has involved an involuntary status. Patients describe being asked on admission to the public facility if they have private health insurance. They are then approached by the Patient Liaison Manager who details the benefits of being a private patient and then signs the patient up. The CEO reporting this activity felt this must be a great additional revenue stream for the public Hospital. It is a widespread practice in the general health areas as public Hospitals struggle to balance their budgets. There may be an ethical issue here when involving mental health patients in accessing private health insurers, especially

if they have involuntary status or even the threat of involuntary status ie. if you don't remain in Hospital we'll make you involuntary.

Ms Selleck (Medibank Private) and Ms Eriksson (HCF) reported that they have investigated this issue and found a very low incidence of such cases being reported to these two major Health Insurers (constituting well over 30% of the industry). Generally, if a health fund Member chooses to be treated in a public Hospital and elects to be a private patient, then that choice is respected. Should, however, it be brought to a Health Insurer's attention that a public Hospital is using undue influence, then that situation would be followed up by the Health Insurer.

Ms Munro and Ms Turnbull reported that this matter had been discussed at the APHA Psychiatry Committee and the cross section of private Hospital CEO's present reported no experience with the sort of practice described above.

The Meeting then considered the possible ethical issues involved with this practice particularly in relation to involuntary status, which appears confusing. Under current legislation that allows a person to be admitted involuntarily, they do not have any choice. In other words, when a person is *scheduled* it is the state saying you will be admitted to Hospital. So how can a person give informed financial consent when they are not able to give informed consent to their admission? This seems to be legally incompatible and may require a legal opinion. After discussion, the Meeting agreed that the PMHA should formally refer this matter onto the Private Health Insurance Ombudsmen, the APHA and the Private Healthcare Australia.

Resolved (unanimous)

That the Private Mental Health Alliance (PMHA) request that the Chair write to the Private Health Insurance Ombudsmen, the Australian Private Hospitals Association and the Private Healthcare Australia concerning the reported practice whereby undue pressure may be being placed on patients with a mental illness who are admitted to a public facility to take up private health insurance.

Action: PMHA Chair/PMHA Director

14.2 First Episode Psychosis

Dr Grant Sara in the course of his doctorate is investigating the incidence of first episode psychosis in New South Wales. In the course of this investigation Dr Sara has found a marked socio–demographic bias in the distribution whereby young people with first episode psychosis appear to be predominantly from lower socio–demographic groups. Dr Sara suggested there may be several interpretations of that, one of which may be that people with first episode psychosis from higher socio–demographioc group are more likely to have private health insurance and are therefore more likely to be admitted to private Hospitals. Dr Sara is seeking the permission of the PMHA for Mr Morris–Yates to investigate that possibility and provide a report.

The Meeting considered this ad hoc request and agreed this task should be undertaken as it will also provide useful information for PMHA stakeholders. The Meeting also agreed that, given the current resource constraints of the CDMS, ad hoc requests for

CDMS data should be considered on a case-by-case basis with requests declined if they are not of more general relevance for PMHA stakeholders.

Resolved (unanimous)

1. *That the Private Mental Health Alliance (PMHA) requests that its Centralised Data Management Service (CDMS) provide a report for Dr Grant Sara to test the hypothesis that people with first episode psychosis from higher socio–demographic groups are more likely to have private health insurance and are therefore more likely to be admitted to private Hospitals.*

Action: CDMS Director

2. *That the PMHA agrees that to accommodate current CDMS resource constraints, ad hoc requests for CDMS data will be have to be declined, unless it can be demonstrated that the ad hoc request is of relevance for all PMHA stakeholders.*

15 PMHA MEETINGS 2012

The Meeting noted the next two meetings of the PMHA and its QIPSC will be held as follows for 2012.

VENUE	MEETING	DATE	TIME
The Adelaide Clinic 33 Park Terrace Gilberton South Australia	5th QIPSC	Thursday, 14 June 2012	3:00 PM – 5:30 PM
	17th PMHA	Friday, 15 June 2012	9:00 AM – 3:00 PM
	6th QIPSC	Thursday, 8 November 2012	3:00 PM – 5:30 PM
	18th PMHA	Friday, 9 November 2012	9:00 AM – 3:00 PM

Dr Choong–Siew Yong gave an advance apology for the June 15 PMHA Meeting.

16 CLOSE

There being no further business, the Chair closed the Meeting at 2:45 PM.

Mr Philip Plummer
PMHA Independent Chair

Mr Phillip Taylor
PMHA Director (Secretary)