PMHA | PRIVATE MENTAL HEALTH ALLIANCE

REPORT AND RESOLUTIONS OF THE SEVENTH PMHA MEETING

HELD ON

FRIDAY, 13 FEBRUARY 2009

AT

ADELAIDE CLINIC
33 PARK TERRACE
GILBERTON
SOUTH AUSTRALIA

Glossary of Acronyms and Terms
used in this Report

AHIA	Australian Health Insurance Association
AHMAC	Australian Health Ministers Advisory Council
AMA	Australian Medical Association
APHA	Australian Private Hospitals Association
APS	Australian Psychological Society
CPoC	Consumer Perceptions of Care Project
DoHA	Australian Government Department of Health and Ageing
HCP	Hospital Casemix Protocol
Health Insurer(s)	Private Health Insurers that pay benefits for psychiatric care
Hospital(s)	Private Hospital(s) with psychiatric beds
MHSC	Mental Health Standing Committee of the AHMAC Health Priorities Principal Committee
MHISS	Mental Health Information Strategy Sub–committee of the MHSC
Network	Private Mental Health Consumer Carer Network (Australia)
PMHA	Private Mental Health Alliance
PMHA–CCMWG	PMHA Collaborative Care Models Working Group
PMHA–CDMS	PMHA–Centralised Data Management Service
PMHA–CDMS MC	PMHA–CDMS Management Committee
SQPS	Safety and Quality Partnership Sub–committee of the MHSC

1. OPENING AND WELCOME

The Chair, of the Private Mental Health Alliance (PMHA), Mr Philip Plummer, opened the Seventh (7th) Meeting of the PMHA (the Meeting) at 10:00 AM on Friday, 29 January 2009.

The Meeting was held at the Adelaide Clinic, 33 Park Terrace, Gilberton, in South Australia.

The following representatives were in attendance.

1.	Mr Philip Plummer	Chair
2.	Ms Janne McMahon	PMHA Consumer Representative
3.	Dr Bill Pring	AMA
4.	Dr Choong–Siew Yong	AMA
5.	Ms Moira Munro	APHA
6.	Ms Carol Turnbull	APHA
7.	Ms Helen Eriksson	AHIA
8.	Mr Greg Kovacs	AHIA
9.	Ms Robyn Milthorpe	DoHA Mental Health Reform Branch
10.	Mr Peter Callanan	DoHA Private Health Insurance Branch
11.	Mr Allen Morris–Yates	PMHA–CDMS Director
12.	Phillip Taylor	PMHA Director (Secretary)

1.1 Apologies and changes in representation

1.	Ms Ruth Carson	PMHA Carer Representative

The Chair reported that Ms Milthorpe had succeeded Ms Therese Merten, as one of the two DoHA representatives on the PMHA.

2. Report of the last (Sixth) PMHA Meeting

The PMHA adopted the draft report of its last meeting.

Resolved (Ms Munro/Ms McMahon)

1. *That the Private Mental Health Alliance (PMHA) adopts the Report of the Sixth PMHA Meeting, held on 10 October 2008 in Canberra, as a true and accurate record of proceedings.*

2. *That the PMHA directs that the Report of the Sixth PMHA Meeting be made available on the PMHA website at: www.pmha.com.au.*

Action: PMHA Director

3. PROGRESS REPORT ON MATTERS ARISING

The Meeting updated the following Table of Progress on actions arising from the 6th PMHA Meeting.

TABLE OF PROGRESS	RESPONSIBILITY	STATUS
Agenda Item 2: PMHA Meeting Reports		
Post Report of 5th PMHA Meeting and PMHA Workshop on PMHA Website	PMHA Director	Done
Draft and circulate for comment Report of 6th PMHA Meeting held on 10 October 2008	PMHA Director	Done
Revise Report of 6th PMHA Meeting and prepare final	PMHA Director	Done
Agenda Item 7th PMHA Meeting	PMHA Director	Done
Agenda Item 4 AMA Financial Statements		
Carry forward surplus in PMHA budget to 2007–08 FY Budget and return 1/5 share of surplus to RANZCP	PMHA Director/AMA	Done
Carry for surplus in PMHA–DMS Budget to 2007–2008 FY Budget	PMHA Director/AMA	Done
Carry forward surplus in Network budget to 2007–08 FY Budget and return 1/6 share of surplus to RANZCP	PMHA Director/AMA	Done
Agenda Item 7th PMHA Meeting	PMHA Director	Done
Agenda Item: 5 Progress Report 2007–2009		
Forward copy of Progress Report to Parties to AMA Agreement for Services 2007–2008	PMHA Director	Done
Post a copy of Progress Report on the PMHA Website	PMHA Director	Done
Agenda Item 6 PMHA–CDMS Management Committee Report		
Agenda Item 7th PMHA Meeting	PMHA Director	Done
Agenda Item 7: Collaborative Care Models Working Group (CCMWG)		
Invite RANZCP, RACGP, ACMHN, APS, AASW and AAOT to participate on CCMWG	PMHA Director	Done
Co–ordinate arrangements for 1st CCMWG Meeting @ AMA House in Canberra on 14 November 2008	PMHA Director	Done
Agenda Item 7th PMHA Meeting	PMHA Director	Done
Agenda Item 9.2: National Mental Health Policy and 4th National Mental Health Plan (NMHP)		
Advise MHSC the PMHA Nominee to NMHP Reference Group is Ms Moira Munro	PMHA Director	Done
Request second PMHA representative for NMHP Reference Group and nominate Dr Bill Pring	PMHA Director	Done
Agenda Item 9.3: Establishment of a National Comorbidity Collaboration (NCC)		
Advise MHSC the PMHA Nominee to NCC is Ms Carol Turnbull	PMHA Director	Done
Agenda Item 9.4: National Perinatal Depression Initiative (NPDI)		
Advise MHSC the PMHA Nominee to the NPDI is Dr Choong–Siew Yong	PMHA Director	Done
Agenda Item 9.6: Nationally Agreed Building and Design Guidelines		
Advise MHSC the PMHA Nominee Speaker for initial Guidelines workshop is Ms Carol Turnbull	PMHA Director	Done
Advise MHSC that the Chair of the Network, Ms Janne McMahon, wishes to attend the workshop	PMHA Director	Done
Agenda Item 10.1: Joint Review of ACT Health's Psychiatric Unit		
Advise ACT Health PMHA is unable to participate in review of its Psychiatric Unit	PMHA Director	Done
Agenda Item 10.3: Mental Health Funding Methodologies: Roundtable Discussion Paper		
Forward discussion Paper to MHSC and ascertain MHSC views.	PMHA Director	Done
Advise MHSC that PMHA would want to be closely involved, if the reforms proposed are progressed	PMHA Director	Done
Agenda Item 10.4 AMA Agreement for Services 2009–2012		
Draft AMA Agreement for Services for 1 July 2009 to 30 June 2012 (3 Financial Years)	PMHA Director	Done
Next PMHA Meeting		
Organise 7th PMHA Meeting for 30 January 2009 @ The Adelaide Clinic	PMHA Director	Done
Prepare and circulate Agenda and Papers for 7th PMHA Meeting	PMHA Director	Done

4. AMA FINANCIAL STATEMENTS

The Meeting discussed copies of the AMA Statements of Income and Expenditure for the PMHA, its CDMS and the Network, for the period 1 July 2007 to 30 November 2008, as they appear at Appendix A of this Report.

Resolved *(unanimous)*

That the Private Mental Health Alliance (PMHA) adopts the AMA Statement of Income and Expenditure for the PMHA, its Centralised Data Management Service (PMHA–CDMS), and the Private Mental Health Consumer Carer Network (Australia) [Network], for the period 1 July 2007 to 30 November 2008.

5. PMHA–CDMS MANAGEMENT COMMITTEE (MC) REPORT

The Meeting noted and adopted the report of the sixth face–to–face meeting of the MC, held on 9 October 2008, and the reports of the MC's monthly teleconferences held on 13 November and 15 December 2008. The MC Chair, Dr Bill Pring, provided the following verbal summary on the last MC meeting, which was held yesterday.

- The PMHA–CDMS Director, Mr Allen Morris–Yate, will prepare discussion papers on the issues that need to be resolved in the revision of the *National Model for the Collection and Analysis of a Minimum Data Set with Outcome Measures for Private, Hospital–based, Psychiatric Services*, for consideration by the next face–to–face meeting of the MC.

- MC is following–up with Queensland Health as to whether the final report of the Consumer Perceptions of Care Pilot Study can be released to the Australian Government.

- MC has noted that, under the new legislation, Health Insurers are required to pay a minimum uncapped benefit for those people who receive psychiatric care in a private hospital. There is some confusion concerning the application of the new requirements. Health Insurers and Hospitals will be discussing this matter further.

- MC is looking at the range of complex issues involved in the use of CDMS and other data for quality assurance purposes. The current Government is committed, through a range of mechanisms, to the development of performance indicators related to the quality and outcomes of health care that is delivered within the Australian health care system. MC has agreed for this matter to remain an agenda item for continued discussion at future meetings.

- In response to a letter from PMHA, DoHA is investigating the provision of Hospital Casemix Protocol (HCP) data directly to the CDMS. This is the first external request for unit level data that DoHA has received in a number of years, and has required consideration of current legislative Acts and Departmental policy as it applies to the request. DoHA will advise PMHA as soon as a decision has been reached by DoHA's legal advisers. Hospitals that currently do not participate in the CDMS account for between 20% and 25% of activity.

Provision of data to the CDMS by the Australian Government would enable the CDMS to generate more complete statistics for benchmarking and national reporting purposes.

- Mr Morris–Yates is currently working on the re–building of the CDMS Data Warehouse.

- MC has agreed that when the National Standards for Mental Health Services are released there should be a concerted effort from the private sector to promote the Standards being integrated into the standards of accrediting bodies and used within the context of one survey.

- MC attended a site visit of the offices of the PMHA's CDMS in Eden Hills where Mr Morris–Yates provided an overview of the security arrangements and equipment for the CDMS.

- MC has agreed to recommend to PMHA that Mr Morris–Yates company, Datasystematics, auspice a proposed project of the Private Mental Health Consumer Carer Network (Australia) to progress some of the recommendations arising from the Indentifying the Carer Project. MC's recommendation is based on this being a one–off project and all work for the project being undertaken in Mr Morris–Yates personal time. The work would involve administrative oversight of the Project with the day–to–day management being the responsibility of the Project Manager, Ms Janne McMahon.

Resolved (unanimous)

1. *That the PMHA adopts the following reports en bloc.*

   - *Report of the Sixth Face–to–Face Meeting of the PMHA–CDMS Management Committee held on 9 October 2008 in Canberra.*

   - *Report of the Seventh Monthly Teleconference of the PMHA–CDMS Management Committee held on 13 November 2008.*

   - *Report of the Eighth Monthly Teleconference of the PMHA–CDMS Management Committee held on 15 December 20008.*

2. *That the PMHA endorses the PMHA–CDMS Director's private company, Datasytematics, auspicing the project proposed by the Private Mental Health Consumer Carer Network [Australia] to progress the recommendations of the Indentifying the Carer Project. All support provided by Datasytematics must be undertaken outside of the PMHA–CDMS Director's full–time employment contract with the AMA.*

6. PMHA COLLABORATIVE CARE MODELS WORKING GROUP (CCMWG)

The Meeting noted a copy of the Draft Report of the Inaugural Meeting of the CCMWG held on Friday, 14 November 2008 in Canberra. The next meeting will be held on Friday, 13 March 2009 in Canberra.

The Chair of the CCMWG, Mr Phillip Taylor, reported on the following.

6.1 Principles for Funding Private Mental Health Service Delivery

CCMWG has considered the agreed Principles that emerged in the development of the *Options for Funding Service Delivery for Private Psychiatric Services: Discussion Paper 2006*. CCMWG revised those Principles for consideration by this meeting of the PMHA. After discussion, PMHA passed the following resolution.

Resolved *(unanimous)*

That the PMHA endorses and adopts the following General Principles for Funding Private Mental Health Service Delivery, prepared by the PMHA Collaborative Care Models Working Group.

General Principles for Funding Private Mental Health Service Delivery

The development of new models of private mental health service delivery and their associated funding arrangements should meet the following criteria.

1. *Provide significant incentives for the implementation of evidence–based best practice models of service delivery.*
2. *Maximise coordination between all relevant providers of health services to improve the coordination of patient care. This includes the coordination between:*
   a. *Providers who work independently.*
   b. *Providers who work in the public sector and private sector.*
   c. *Providers of services other than health services such as housing and protective agencies.*
3. *Eliminate or significantly reduce incentives for the provision of clinically unnecessary or inappropriate use of overnight inpatient care, or any other form of hospital–based, or other psychiatric care. New models of service delivery and their associated funding arrangements should be judged on the following criteria.*
   a. *The effectiveness with which the needs of consumers and their carers are met.*
   b. *The efficiency with which the required services are able to be delivered.*
   c. *The extent to which financial risk is equitably shared between providers and payers, or is controlled by other mechanisms.*

It is acknowledged that private health insurers and other payers are not able to fund all the services that it may be desirable to have available. Models of service delivery that clearly require increased expenditure by payers should also meet the following additional criteria.

1. *The disease, syndrome or condition for which services are to be delivered should be a recognised psychiatric condition.*
2. *The proposed model of service delivery and its constituent therapeutic interventions should be based on evidence that they represent current best–practice.1*

The development of new models of service delivery with associated funding arrangements are encouraged to provide appropriate funding for the implementation of evidence–based best practice models of service delivery.

---

1. *This does not imply that the model of service delivery or all of its components must be evidence–based in the strict sense of that term. It is acknowledged that many aspects of service delivery and certain therapeutic interventions used in psychiatry may not have a firm evidentiary base. Accordingly, this criteria specifies that services should be modelled on what can be shown to be recognised by authoritative clinical consensus to be current best practice.*

6.2 Review of the *Guidelines for Determining Benefits for Health Insurance Purposes for Private Patient Hospital–Based Mental Health Care (2007 Edition)*

CCMWG has recommended that PMHA consider directing CCMWG to undertake the revision of these Guidelines, rather than establishing another working group.

Resolved *(unanimous)*

That the PMHA requests that its Collaborative Care Models Working Group undertake the revision of the Guidelines for Determining Benefits for Health Insurance Purposes for Private Patient Hospital–Based Mental Health Care (2007 Edition) in 2009.

Action: PMHA Director

6.3 Review of the *Options for Funding Service Delivery for Private Psychiatric Services: Discussion Paper 2006*.

CCMWG is revising this Discussion Paper.

6.4 Representation

There have been some difficulties obtaining a GP representative from RACGP. Dr Choong–Siew Yong offered to follow this up with the AMA.

Ms Helen Eriksson suggested that, if invited organisations are unable to provide a representative, then their involvement could be sought by way of provision of comments on work undertaken by CCMWG.

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

The last meeting of the Network was held on 18/19 August 2008 in Melbourne and the next will be held in Melbourne on 16/17 February 2009.

The Independent Chair of the Network, Ms Janne McMahon, reported on the following Network activity.

7.1 Health Insurers conducting pilot projects

The Network made a recent submission to DoHA's Private Health Insurance Branch concerning the ability of Health Insurers to conduct pilot projects. The Network supported Health Insurers conducting such pilots and made the following points.

- The principle of community rating should be retained.
- If pilots are successful they should be implemented.
- Scope purpose of the projects should be clear.
- Pilots should be evaluated by an independent evaluator.
- If a pilot runs for two years people get used to it and may not realise it is a pilot and that it may not continue.

- Transitional arrangements need to be in place for people who are involved in pilot projects, particularly if they are long–term.

- Good partners would be the private hospitals and their psychiatrists.

Ms Eriksson responded that there are a range of issues for Health Insurers involved with these pilots. The issue of transitional arrangements for the two year pilots will need to be addressed.

7.2 Men's Health

The Network will be making a submission to the Select Committee on Men's Health, which has been established to inquire into general issues related to the availability and effectiveness of education, support and services for men's health, including but not limited to:

1. level of Commonwealth, state and other funding addressing men's health, particularly prostate cancer, testicular cancer, and depression;

2. adequacy of existing education and awareness campaigns regarding men's health for both men and the wider community;

3. prevailing attitudes of men towards their own health and sense of wellbeing and how these are affecting men's health in general; and

4. the extent, funding and adequacy for treatment services and general support programs for men's health in metropolitan, rural, regional and remote areas.

Submissions are due by 27 February 2009.

7.3 National Primary Health Care Strategy

The Network will be responding to the call for public submissions in response to the discussion paper titled, *Towards a National Primary Health Care Strategy*.

7.4 Australian Bureau of Statistics (ABS) National Survey of Mental Health and Wellbeing 2007

The Network was invited by DoHA to attend a Forum held in Canberra on Friday, 14 November, 2008 concerning the findings of the ABS National Survey of Mental Health and Wellbeing 2007 (Survey). The Network's New South Wales State–based Coordinator, Ms Alvina Hill, attended the Forum on behalf of the Network.

7.5 Senate Community Affairs Committee Inquiry into Mental Health

The Network raised the issue of the correlation between childhood sexual abuse and the development of mental illness in adulthood with this Inquiry through a coalition submission from three national mental health consumer and carer advocacy peak bodies and through numerous letters of support from key organisations. The Inquiry made several recommendations to address these issues. The Network Chair and Professor Louise Newman met on 15 December 2008 with Dr Phuong Pham in Canberra to discuss these recommendations further. Dr Pham is the advisor on

mental health to the Commonwealth Minister for Health and Ageing, The Hon. Nicola Roxon MP. Dr Pham gave an assurance these recommendations would be brought to the Minister's attention.

7.6 New Zealand (NZ) Connection

During a visit to NZ to attend the meeting of the 26 October 2008 RANZCP Board of Professional and Community Relations, Ms McMahon met with Dr Stephanie du Fresne, the Medical Director of Ashburn Clinic. Ashburn Clinic is one of only two private hospitals in NZ. Dr du Fresne is keen to fund a consumer and carer to attend a meeting of the Network in Melbourne to determine whether the Ashburn Clinic should become further involved with the Network.

7.7 International Initiative For Mental Health Leadership (IIMHL)

The Network and Ramsay Health Care South Australia have agreed that it would be worthwhile to host a consumer and/or carer representative in Adelaide as part of the IIMHL. Unfortunately the closing date for exchange placements was two weeks ago (refer to Agenda Item 8.10 in this Report).

7.8 RANZCP Curriculum Improvement Project (CIP)

Representatives of the Network are meeting with RANZCP CIP Executive to explore opportunities for collaboration and the potential for integration of issues related to carers and consumers within the College's Fellowship Program. Given the potential for the development of learning resources, a representative of the Continuing Medical Education (CME) program is also exploring collaboration within the context of the professional development program.

7.9 Incorporation of the Network

The PMHA, its CDMS and the Network are currently supported under an *AMA Agreement for Services 2008–2009* between the AMA, the Australian Government, the Australian Private Hospitals Association (APHA), and the Australian Private Health Insurance Association (AHIA) and beyondblue. This Agreement will expire on 30 June 2009, so the next funding agreement needs to be negotiated over the next few months to provide certainty for these activities.

At the 6th PMHA meeting, AMA representatives encouraged the Network to investigate setting itself up as an independent incorporated body to give the Network more independence in the scope of the work that it does and make it less reliant on AMA for administrative support.

Since that meeting, the Network has investigated the process of incorporation. It is anticipated, however, that the preferred position of the 16/17 February 2009 Network meeting will be for the Network to remain under the auspice of the AMA for the period of the proposed new funding agreement 1 July 2009 to 30 June 2012 and work toward becoming an incorporated body at the end of that time. Informal feedback from three of the other stakeholders (APHA, AHIA and DoHA) has also suggested a strong view for the current arrangements to continue for two reasons. Firstly, the AMA's financial and administrative contribution gives the Network credibility and provides reassurance in respect of financial accountability for these

stakeholders. Secondly, they view the Network as part of a "package" for the private sector.

Dr Choong–Siew Yong and Dr Bill Pring reported that the AMA Executive Council has considered these issues and agreed to the negotiation of a new three year funding agreement for the PMHA, its CDMS and the Network with the AMA contribution of $67,598 in 2009–10, $70,567 in 2010–11, and $73,666 in 2011–2012. The terms and conditions of AMA support for the Network will be clarified through a letter from the Secretary General to the Network Chair.

Subsequent to the Incorporation issue being raised by the AMA, DoHA raised the concerns about the Network's succession planning and sustainability. This has lead to a request for additional funding from DoHA for the position a Network Deputy Chair and Administrative Officer, being incorporated into the negotiations for the new three year funding agreement.

7.10 Network Administrative Officer

The AMA has completed its investigation of the best arrangements for the services performed by a Network Administrative Officer. The AMA have undertaken an employment contract with Ms Therese Burgess to perform this role from the home of the Network's Independent Chair in Adelaide within the limits of the $10,000 funding donated to the Network by the Royal Australian and New Zealand College of Psychiatrists.

8. 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 last meeting of the MHSC was held in Melbourne on Friday, 6 February 2009. The PMHA Chair, Mr Philip Plummer, and PMHA Deputy Chair, Ms Moira Munro, attended that meeting. A summary of the update for the PMHA provided by Mr Plummer and Ms Munro is set out below. In opening, Mr Plummer and Ms Munro requested that PMHA representatives on MHSC sub–groups be mindful to make contact via phone or email following meetings of these subgroups and advise of the outcomes.

8.1 National Mental Health Policy and Fourth National Mental Health Plan

At its meeting of 22 July 2008, AHMC noted the revised *National Mental Health Policy* (the revised Policy) and agreed to the development of a *Fourth National Mental Health Plan* (the Fourth Plan). Development of the Plan was referred to the MHSC with the Fourth Plan to be informed by the revised Policy and to be developed in the context of a whole of government approach. HPPPC has endorsed the approach proposed by the MHSC for development of the Fourth Plan.

Reference Group **–** The Reference Group reports back to HPPPC through the MHSC and is chaired by HPPPC's Mr Peter Allen. The two PMHA representatives that have been appointed to the Reference Group are Ms Moira Munro, and Dr Bill Pring. Dr Pring attended the meetings of the Reference Group held on 8 December 2008 and 29 January 2009 with Ms Carol Turnbull as proxy for Ms Munro. A further Reference Group meeting is proposed for 31 March 2009 in Melbourne. Dr

Pring will attend this meeting and Ms Munro will advise as to whether it will be Ms Turnbull who will attend again with Dr Pring.

Working Group – A Working Group has undertaken the detailed development of the Plan. The Working Group has met on a number of occasions, and is scheduled to meet on 4 March in Brisbane and again in Canberra on 24 March 2009.

Consultants – Dr Ruth Vine is the lead consultant for the development of the Plan. The Department of Health and Ageing has also contracted Mr Bill Buckingham, Associate Professor Jane Pirkis, and Margaret Goding to assist in the reporting of consultations with Ministerial Advisory Councils and to develop the monitoring and evaluation elements of the Plan.

Consultation – Consultations have already commenced in some jurisdictions, and will be held throughout February and early March 2009. The Commonwealth is conducting National Consultations on 18/19 February in Canberra. A National Forum is proposed to be convened on Wednesday, 29 April in Melbourne. The intention of the Forum would be presenting the final draft Plan to key stakeholders and outlining ways forward to implement the Plan once endorsed by AHMC.

8.2 National Comorbidity Collaboration (NCC)

NCC was established to assist the Commonwealth and the States and Territories to focus on comorbidity issues and identify opportunity for shared priorities and interests in a whole–of–government approach.

The PMHA is represented on the NCC by Ms Carol Turnbull, who was appointed after the NCC's first meeting.

PMHA noted that the first meeting of the NCC was held on 16 September 2008 in Brisbane and focused on exploring models of care and quality improvement processes within the alcohol and other drug (AOD) sector, better integration with the mental health sector, coordination of comorbidity initiatives, workforce development, and capacity building. Agreement was reached on the composition of membership to the NCC, as well as the co–chairing arrangement between Ms Virginia Hart (Assistant Secretary, Drug Strategy Branch, Department of Health and Ageing) and Dr John Crawshaw (CEO Mental Health Services, Department of Health and Human Services, Tasmania). Members of the NCC agreed that there was a reasonable level of activity regarding generic quality within the AOD NGO sector and that any attempt to develop a national model for a quality framework would be difficult to progress and would add little value at this stage. Members agreed to the following set of principles governing NCC work:

- it must be evidence based
- flexible enough to apply across the different jurisdictions and sectors
- considers the questions 'what can be different?' or 'what do we want to see?'
- must focus on comorbid clients regardless of the service or provider type

- must move away from initial brief confining the scope of AOD NGOs
- consistent use of language is required highlighting the need for definitions.

Next steps for the NCC include:

- the development of a scoping paper on the identified priority areas. These include access, interface and linkages, models of care, workforce development, capacity building, leadership, data and indicators, and minimum conditions of funding. The NCC work plan will address these priorities in turn, commencing with models of care.
- The consideration of strategies to enhance consumer participation in AOD services, and to include other stakeholders in the work of the NCC.

A teleconference will be held in March. Mr Taylor was asked to forward Ms Turnbull's contact details again to the MHSC Secretariat.

8.3 National Perinatal Depression Initiative Working Group (NPDIWG)

The MHSC meeting held on 19 September 2008 noted that the National Perinatal Depression Initiative Working Group (NPDIWG), which had been established to progress the development of a National Perinatal Depression Initiative (including financial arrangements, anticipated monitoring arrangements and expected deliverables) had already held two meetings. Following the MHSC's September meeting, two further meetings of the NPDIWG were held to finalise implementation arrangements for the key elements of the Initiative, including routine and universal screening, workforce training and development, follow up care and support for women at risk of or experiencing perinatal depression, and community awareness.

The PMHA is represented on the NPDIWG by Dr Choong–Siew Yong.

The NPDIWG has developed and agreed to a draft national framework for perinatal depression for the MHSC's consideration and submission through the Health Policy Priorities Principal Committee (HPPPC) to AHMAC. The draft framework describes the scope of the initiative, the roles and responsibilities of the Australian Government, State and Territory Governments and *beyondblue*, the key elements and the underlying principles for implementation. The monitoring arrangements for the initiative have not yet been finalised by MHISS and are not yet included in the draft framework. The draft framework will also contain investment plans from each Government that set out the financial investment and activities each will undertake to achieve the outcomes that have been agreed by the NPDIWG. Once MHISS and the NPDIWG have agreed to the monitoring arrangements, approval of the entire draft framework will be sought from MHSC. To fit with HPPPC and AHMAC meeting dates, this may need to occur out–of–session for the MHSC. The complete draft framework will then be submitted through the HPPPC meeting on 21 April 2009 to AHMAC for endorsement at its 4 June 2009 meeting.

Mr Taylor was asked to forward Dr Yong's contact details again to the MHSC Secretariat.

8.4 SCAG referral – Proposal for Uniform, Ethically Informed and Proposal for Uniform, Ethically Informed and Evidenced Based mental Health Law Reform in Australia

The Standing Committee of Attorneys–General (SCAG) has referred a proposal to standardise Australian state and territory mental health law, so that the major criterion for non–consensual treatment of people with severe mental illness is loss of decisional capacity rather than perceived risk to self or others, to AHMAC for information and any action as considered appropriate. The paper calls for uniformity across all jurisdictions in regard to non–consensual treatment for those with mental illness. Additionally, the paper calls for the standardisation of non–consensual treatment to be based on a person's capacity to consent to treatment rather than risk to self or others. The authors, Dr's Ryan, Large, Nielssen, Crim and Hayes, submit that an individual who is incapable of decision making regarding their health, due to mental illness, will receive non–consensual treatment. The decision making body proposed in the submission is a magistrate or properly constructed tribunal.

8.5 Mental Health Workforce Advisory Committee (MHWC) Update

MHWAC next meets on 20 February 2009 to consider the National Primary Health Care Strategy, the developments in national health workforce including establishment of the national agency, and Non–government mental health workforce. Key actions taken since the last MHWC meeting are as follows.

- ***Web–based Professional Education Project (MHPOD).*** Focus testing of the pilot topics commenced in December 2008. Feedback has been positive with comments from staff in a variety of roles in most jurisdictions. Articulation of the modules into a suitable university award course is being explored, as one option to encourage uptake. More topics will be written and produced in 2009, and consideration is being given to rollout options.

- ***National Practice Standards for the Mental Health Workforce Implementation Project.*** This project is concluding and a meeting of the six pilot sites will be held on 6 February 2009. The initial focus was on four standards, (1) consumer and carer participation, (2) mental health problems and mental disorders, (3) assessment, treatment, relapse prevention and support, and (4) documentation and information systems. Work on the remaining eight standards is underway. The implementation framework includes a focus on performance elements for different levels of staff.

- ***Mental Health Skills Articulation Framework between the Vocational Education and Training and Higher Education Sectors Scoping Report.*** A submission was made to the Community Services and Health Industry Skills Council in November 2008 regarding the draft report.

- ***Jurisdictional Workforce Templates.*** MHWAC repeated the information gathering exercise on workforce activities that was first undertaken in 2006. Responses were collated and analysed for MHWAC's October 2008 meeting. In general, the templates demonstrated a strong emphasis on nursing, and to a lesser extent, on medical staff. Workforce activities related to psychology have increased significantly since 2006. There is now more activity regarding

ensuring and sustaining workforce supply; distribution; and optimal use of skills and workforce adaptability than was the case two years ago. Further editing for consistency is required before the templates are placed on the web.

- ***National Mental Health Workforce Strategy and Plan.*** A project brief was developed and circulated to MHWAC jurisdictional members and the HWPC member for endorsement. A formal request for funding has been made to the Commonwealth.

- ***Mental Health Nurse Education Taskforce (MHNET).*** Follow–up visits with nursing and midwifery registration authorities and other groups are being arranged to promote implementation of the recommendations.

8.6 Nationally Agreed Building and Design Guidelines

ACT Health hosted an issues workshop on mental health facility design on 2 December 2008 in Canberra to inform the revision of the current Australasian Health Facility Guidelines (AHFG) that relate to mental health facilities. The workshop was attended by delegates from all states and territories as well as the private sector (Ms Carol Turnbull and Ms Janne McMahon) and representatives from the Centre for Healthcare Assets Australasia that is facilitating the review of the mental health facility guidelines. Ms Turnbull and Ms McMahon reported that the workshop was largely information sharing and it was noted that the main outcomes were as follows.

- ***Glossary.*** A glossary is to be developed that promotes understanding of the key service subtypes in each jurisdiction. Dr Brown, as the convenor of the workshop and Chair, Safety and Quality Partnership Subcommittee, undertook to develop a glossary through a consultative process with states and territories. This consultation is currently underway.

- ***Further Workshops.*** MHSC agreed to each jurisdiction hosting an issues workshop for a specified service subtype that will then inform the work on the revision of the AHFG and the development of new guidelines.

- ***Expert Reference Groups***. MHSC has agreed to the establishment of an expert reference group for each service subtype to facilitate ease of reference in the revision of the AHFG and to provide a forum for continuing discussion of contemporary models of service for key service type.

Ms McMahon spoke at the workshop about the risks associated with over emphasis on the elimination of hanging points in the development such guidelines and standards. Dr Yong warned that an over emphasis on physical safety can lead to staff complacency, when what is really required is proper screening, assessment and ongoing regular review while a person is in hospital. There seems to also be a growing expectation by some state governments and legal institutions that somehow private hospitals can be secure and hold people in a semi–voluntary manner, rather than a totally voluntary manner. To avoid this problem, the role of the two sectors must remain clear in relation to voluntary and involuntary admissions.

8.7 New National Mental Health Consumer Organisation

The Minister for Health and Ageing and DoHA are committed to establishing a strong, unified and participative peak mental health consumer organisation. Ms Munro reported that on 19 November 2008, DoHA brought together a group of representative consumer experts drawn from a range of consumer organisations to collectively consider the elements for a new effective national consumer organisation, what a new organisation might look like, and what might be required to establish an organisation within the existing sector. The Expert Reference Group determined a need for a nationally owned, representative and independent consumer voice. As a result of the meeting, the Department is assisting the Expert Reference Group to engage a consultant to produce a discussion paper that identifies options that could be available for future consumer national representation. The consultant is expected to undertake a range of activities that may include:

- identification and analysis of key existing mental health consumer organisations at a national level: and
- identify principles, structures, models business rules that will govern and provide stability and sustainability for the new consumer organisation.

It is anticipated that the consultant will provide a discussion paper to be circulated for comment to the consumer mental health sector by the end of May 2009 and this process may involve consultations in each jurisdiction.

PMHA noted that Ms McMahon attended the 19 November meeting and it was agreed that it would be important for the Network continue to participate in the consultation processes.

8.8 National Mental Health Consumer Carer Forum (NMHCCF) Report

MHSC noted the following activities of the NMHCCF.

Forward Planning In September 2008 the NMHCCF began a detailed review of its *Strategic Plan April 2007–April 2008.* The purpose of the was to identify achievements and agree on a way forward for outstanding tasks as well as draft a plan for the NMHCCF for the next 3 years. Work to be continued under the new Forward Plan has been identified. The NMHCCF Planning Working Group has been formed to complete the plan at a facilitated workshop on the 26/27 February 2009 in Sydney. It is anticipated that the product of this workshop will be a detailed Operational and Work Plan for 2009–11 that outlines the key actions and deliverables over the coming 12– 18 months given existing staffing and resources.

Funding. Since the last MHSC meeting the Department of Health and Ageing have provided the extra funding to the NMHCCF for business planning, development of the NMHCCF website, attendance at the annual workshop for the National Register of Consumers and Carers being run by the Mental Health Council of Australia (MHCA), and administrative support.

New Brochure for the NMHCCF. NMHCCF has developed a new brochure and has circulated around 3,500 copies.

Training. During 2008 the NMHCCF undertook extensive communications skills training with several sessions being presented using a conflict resolution framework. Further training sessions in policy development have been proposed.

Seclusion and Restraint A Draft Discussion Paper for consultation is nearly complete. A Copy has been circulated to the MHSC Safety and Quality Partnership Sub-committe (SQPC) for comment. NMHCCF has also recently provided input to the SQPC draft definitions, principles and procedures around seclusion and restraint.

Privacy and Confidentiality Proposals for the development of a discussion paper for consultation are being considered. It is hoped that this project will identify the issues and solutions to the challenges facing consumers and carers about communication with clinicians on this.

Research The Planning Working Group is also in discussions with an ANU PhD student who is keen to conduct a research project on the NMHCCF business model and analyse the factors contributing to its success. This project is likely to provide a documentation of the NMHCCF business model (including any possible changes that occur over this period) for use by NMHCCF members. The NMHCCF sees potential in this product for promotion and discussion in the broader consumer and carer sector.

8.9 Global Linkages

MHSC is looking at the issue of global linkages directed toward showcasing Australian health care. After discussion, Ms Milthorpe agreed to obtain further information for the PMHA with respect to what has been done to date and what might be planned.

8.10 International Initiative on Mental Health Leadership (IIMHL)

The MHCA has raised the question of increasing the number of consumers at meetings of the IIMHL. IIMHL was launched in June 2003 with founding members of Great Britain, USA and New Zealand. Australia is now a member and the main purpose of the IIMHL is to build leadership between chief executive officers and general managers of mental health services through international exchanges and peer relationships, focusing on best management practice and evidence–based clinical practice. The exchange program of the IIMHL comprises site visits and workshop activity that brings together the host sites and international visitors. Jurisdictions sponsor participants to visit overseas within the program and those jurisdictions are required to meet travel and accommodation costs. Some positions have been made available for emerging leaders. PMHA noted that Ms McMahon has been invited to attend the IIMHL meeting to be held in Brisbane on 5/6 March 2009 as recognised leader.

9. AMA AGREEMENT FOR SERVICES 2009–2012

The last meeting of the PMHA requested that the PMHA Director, Mr Phillip Taylor, draft an *AMA Agreement for Services 2009–2012* (Draft Agreement) covering the three Financial Years from 1 July 2009 to 30 June 2012, for consideration by this Meeting.

A copy of the preliminary Draft Agreement was then considered and Members noted the following.

- The Draft Agreement has been prepared to support the activities of the PMHA, its CDMS and the Network.

- The Draft Agreement is still a ***work–in–progress*** and is the result of the constant refinement of the following Agreements over the past eight years or so.

    - *AMA Agreement for Services 2001–2004* (3 Years)
    - *AMA Agreement for Services 2004–2006* (3 Years)
    - *AMA Agreement for Services 2007–2008* (18 Months)
    - *AMA Agreement for Services 2008–2009* (1 Year)

  The previous Legal Counsel for the PMHA and its antecedent SPGPPS, Ms Jane Ferry, drafted these documents in close consultation with Mr Taylor, Mr Allen Morris–Yates, and all the Parties involved.

- The contributions of respective Parties toward PMHA, its CDMS, and the Network are based on the previously agreed contributions for Financial Years 2009–2010, 2010–2011, and increased by CPI only for 2011–2012, with the exception of the DoHA contribution toward the Network. The Network is seeking some additional funding from DoHA, which does not affect the contributions toward the Network of the Other Parties (AMA, AHIA, APHA and beyondblue).

- A copy of the summary and detailed budgets for PMHA, its CDMS and the Network had been circulated with the agenda and papers for this Meeting for reference.

- There is no longer a PMHA budget to obtain legal advice on the Draft Agreement.

- The AMA has agreed to the negotiation of a new three year funding agreement for the PMHA, its CDMS and the Network with the AMA contribution of $67,598 in 2009–10, $70,567 in 2010–11, and $73,666 in 2011–2012.

Ms Robyn Milthorpe reported that DoHA is unable to commit to any funding agreements until such time as the National Health Agreements are in place.

Ms Eriksson requested that the previously agreed work plans for PMHA, CDMS and the Network be circulated to PMHA members. Mr Greg Kovacs requested the Draft Agreement be circulated with mark–up to identify the changes that have been made.

Resolved *(unanimous)*

That the Private Mental Health Alliance (PMHA) requests that the PMHA Director circulate a copy the draft AMA Agreement for Services 2009–2012 with mark–up to identify the changes that have been made, together with the respective agreed work plans for PMHA, its CDMS and the Network.

Action: PMHA Director

10. KPMG EVALUATION OF THE BETTER ACCESS INITIATIVE

Mr Taylor reported that the Australian Government has engaged KPMG to conduct the stakeholder consultation component of the evaluation of the Better Access to Psychiatrists, Psychologists and GPs through the Medicare Benefits Schedule Initiative (Better Access Initiative). The Meeting noted a copy of the self–explanatory background information from KPMG, which had been circulated with the agenda and papers for this Meeting.

The Chair welcomed Mr Shane Rendalls, Senior Manager, Health and Human Services KPMG and Mr Andrew Dempster, Manager National Health and Human Services Practice KPMG to the meeting.

Mr Rendalls provided an overview of the evaluation and sought feedback from the Meeting. Some of that feedback has been summarised below. Members also provided further feedback over lunch for Mr Rendalls and Mr Dempster.

10.1 General Comment

There has been a large uptake of the Initiative but what outcomes are actually being achieved is not being measured.

10.2 Consumers and Carers

This has been a very important Initiative, which has resulted in greater access and early intervention for consumers through the services provided under the Medicare Benefit Schedule (MBS) by GPs, psychologists, social workers and occupational therapists (OTs), particularly in relation to less complex disorders such as anxiety and depression.

Consumers are concerned over the differences between what registered psychologists and clinical psychologists are able to treat.

Group therapy can add value to treatment. There are, however, difficulties involved in coordinating such programs for the level of remuneration currently available under the Initiative.

10.3 Health Insurers

Health Insurers have limited stake in this Initiative, but in general support better access to these clinical services as they deliver better outcomes for patients in the long term and prevent unnecessary hospitalisation. Health Insurers have experienced some difficulty with members who wished to claim against both the Medicare rebate and Health Insurer rebate (double dipping), which required Insurers to adjust their policies accordingly.

10.4 Psychiatrists

In general, psychiatrists feel the impact of the Better Access Initiative has been very positive. High prevalence disorders are much better treated in the community and there has been an increase in destigmatisation, which is likely to continue.

The impact on psychiatric practice, however, has been fairly limited. This is because the range of services psychologists are providing do not fall within the range of patients seen by psychiatrists. This is partly due to the Medicare rebate for psychologists being irrespective of services they actually provide. A rebate based on complexity would encourage psychologists to take up more complex patients. In the private sector, there is also limited interaction between psychologists and psychiatrists in comparison to the level of interaction between psychologists and GPs. Comments on the Initiative from GPs will, therefore, be very different to those of psychiatrists. The differences between registered psychologists and clinical psychologists have not really addressed the issue of complexity. In rural settings there are very few clinical psychologists, so if you were to limit the access to registered psychologists that would have an impact on patients in rural and remote areas.

The Initiative has had an impact on the public mental health sector as psychologists leave the public sector to take up private practice. The issue of the quality of services being delivered by psychologists also needs to be addressed.

The role that was originally envisaged for mental health nurses working in group practices with psychiatrists has not really worked out, as office–based psychiatry is not structured in the same way as it is for GPs. Firstly, many GPs work in group practices where they pool resources and are geographically well networked through Divisions of General Practice. Secondly, there is already a very well established GP practice nurse structure for the mental health nurses to connect into. Psychiatrists, however, have no such structure. Where there are group practices of co–located psychiatrists, they do not have pooling of resources and the scope of services provided is largely based on the individual practitioners. That is not to say that will not change in the future, but the funding structures are not yet present that would enable that to happen and the Better Access Initiative does not really address this situation. In the interim, however, the experience of psychiatrists with the pilot of the Mental Health Nurse Incentive Program (MHNIP) through well established private hospitals has been very positive and has the potential to be rolled out further.

The secondary consultation role through the use of MBS Item 291 works well for some psychiatrists. Other psychiatrists who want to have an ongoing patient care role have not found 291 to be particularly useful to their style of practice.

Any new planning concerning the Initiative must involve private psychiatrists through both the AMA and the RANZCP. Many of the ideas originally put forward were not properly considered. For example, the AMA had originally suggested that there should be a higher rebate for clinical psychologists that accepted referrals from psychiatrists, which would have encouraged the clinical psychologists to treat more complex cases. The Initiative has resulted in an increase in case identification, but psychiatrists are finding it difficult to find psychologists who are willing to work with them in the longer term on quite difficult cases. The result is that psychiatrists have to do more treatment work, not just 291 work.

There is an impression that the public sector has assumed that the private sector can manage a lot of cases that were previously treated in the public sector. Paradoxically, serious mentally ill people may be finding it more difficult to get care.

In some instances, underlying quite severe diagnoses are not being picked up as the GP has left the diagnosis to the psychologist. The GP finally refers the patient to the psychiatrists who picks up the underlying severe diagnosis. In these cases, an earlier psychiatric assessment may have helped to define what process of treatment should be delivered by the GP and the psychologist.

10.5 Private Hospitals

Private psychiatric hospitals tend not have been directly affected by the Initiative. They employ their own psychologists, mental health nurses and allied health professionals. Anecdotally, however, hospitals are hearing reports similar to those described above, particularly in relation to people who have not been managed well and end up having a crisis because they do not fit the treatment model. The psychiatrist is then called in to undertake the management of a person in crisis. The focus needs to be on the appropriateness of care.

There is a great expectation on private and public hospitals to measure what they are providing for their patients and demonstrate the outcomes of care that are being achieved. There appears to be nothing in the Initiative that addresses this issue.

Private Hospitals have found the pilot of the Mental Health Nurse Incentive Program (MHNIP) very useful, despite the administrative burden that is involved.

10.5 Follow-up

Mr Rendalls and Mr Dempster thanked the Meeting for the feedback provided and Mr Taylor was asked to provide a copy of the minutes when available to Mr Rendall and Mr Dempster.

11. OTHER BUSINESS

11.1 PMHA Newsletter

The Meeting noted a copy of the First Edition of the PMHA Newsletter, which had been circulated with the agenda and papers for the Meeting.

The Meeting thanked Mr Taylor for his work on the Newsletter, which is circulated to the thousand or so contacts listed on the PMHA database.

Mr Taylor reported that the next Newsletter is due for publication in March/April 2009. AHIA have offered to provide a substantive article for that edition. Other possible articles were discussed and it was agreed that the next Edition should include the following.

- Principles for Funding Private Mental Health Service Delivery.
- PMHA–CDMS Update.
- Review of the Guidelines for Determining Benefits for Health Insurance Purposes for Private Patient Hospital–based Mental Health Care.
- Stakeholder Round–Up

Mr Taylor discussed a copy of a draft Fact Sheet for future Newsletters with the Meeting and reported on the difficulties being experienced in determining what the Fact Sheet should contain that is both useful and relevant to the private sector. The Meeting agreed that caution needs to be exercised in the development of the Fact Sheet not only in terms of the accuracy of the statistics, but also the political implications of what might be published. The Meeting requested the draft Fact Sheet be circulated to stakeholders for their input and included on the agenda for the next PMHA Meeting for further discussion.

Resolved *(unanimous)*

1. *That the Private Mental Health Alliance (PMHA) requests that the PMHA Director draft the Second Edition of the PMHA Newsletter for circulation to members of the PMHA and its Liaison Officers for comment prior to publication.*

Action: PMHA Director

2. *That the PMHA requests that the draft PMHA Newsletter Fact Sheet be circulated to stakeholders for discussion with their constituencies and further consideration at the next PMHA meeting.*

Action: PMHA Director/PMHA Members

11.2 Strategies for Promoting the Private Sector.

The Meeting then considered what other strategies might be used to promote the private sector beyond publication of a Newsletter.

Mr Kovacs felt that positive media stories would be useful.

Ms Munro felt research articles and linkages with universities were important.

The Meeting noted that Mr Taylor and Mr Morris–Yates have both submitted articles for the APHA Newsletter on the PMHA and its CDMS.

After discussion, it was agreed that this matter should be included as an ongoing Standing Item on the PMHA agenda.

Resolved *(unanimous)*

That the Private Mental Health Alliance (PMHA) request the issue of PMHA communication be included as a standing item on the PMHA agenda.

Action: PMHA Director.

12. NEXT MEETING

It was agreed that the next PMHA meeting would be held as follows.

8th PMHA Meeting
10:00 AM to 3:00 PM
Friday, 22 May 2009
The Adelaide Clinic

33 Park Terrace
Gilberton South Australia

13. CLOSE

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

Mr Philip Plummer
Independent Chair

Mr Phillip Taylor
PMHA Director (Secretary)

PMHA INCOME (Stakeholder Contributions)	Contribution		
1. Australian Medical Association	54,759		
2. Australian Private Hospitals Association	54,759		
3. Australian Health Insurance Association	54,759		
4. Australian Government Department of Health and Ageing	62,759		
Transfer of PMHA balance from 1 July 2007 to 30 June 2008	*11,400*		
Total	**238,436**		
PMHA EXPENDITURE	**Budget**	**Actual**	**Variance**
Staffing	155,077	67,776	87,301
Infrastructure	6,492	3,301	3,191
Recurrent and other expenses	23,412	3,788	19,624
Meetings of PMHA Face–to–Face	11,476	6,154	5,322
Working Groups	2,912	1,544	1,368
Other Meetings (MHSC & SQPWG)	7,028	843	6,185
Total before AMA Administration charge	206,397	83,405	122,922
AMA Administration Charge of 10%	20,640	20,640	0
Total	**227,037**	**104,045**	**122,922**
Total PMHA Funds Remaining		***134,430***	

PMHA–CDMS INCOME (Stakeholder Contributions)	Contribution		
1. Australian Private Hospitals Association	64,897		
2. Australian Health Insurance Association	64,897		
3. Australian Government Department of Health and Ageing	64,897		
Transfer CDMS Balance From 1 January 2007 to 30 June 2007	*53,473*		
Total	**248,164**		
PMHA–CDMS EXPENDITURE	**Budget**	**Actual**	**Variance**
Staffing	138,326	56,254	82,072
Infrastructure	16,500	41,871	–25,371
Recurrent and other expenses	16,775	5,700	11,075
Attendance at PMHA and other stakeholder's meetings	5,391	1,981	3,410
Workshops	0	3,724	–3,724
Total before AMA Administration charge	176,992	109,530	67,462
AMA Administration Charge of 10%	17,699	17,699	0
Total	**194,692**	**127,229**	**67,462**
Total CDMS Funds Remaining		***120,935***	

NETWORK INCOME (Stakeholder Contributions)	Contribution		
1. Australian Medical Association	11,152		
2. Australian Private Hospitals Association	11,152		
3. Australian Health Insurance Association	11,152		
4. Beyondblue	11,152		
5. Australian Government Department of Health and Ageing	87,101		
Donation from the RANZCP	*10,000*		
Transfer of Network Balance from 1 July 2007 to 30 June 2008	*1,677*		
Transfer McMahon Petty Cash Advance for Network from June 2008	*–2,000*		
Total	**141,386**		
NETWORK EXPENDITURE	**Budget**	**Actual**	**Variance**
Staffing	73,951	24,650	49,301
Meetings of the Network	37,039	14,085	22,953
Infrastructure for Network Chair	520	1,218	–698
Attendance of Network Representative at Other Meetings	8,225	1,764	6,461
Total before AMA Administration charge	119,735	41,717	78,017
AMA Administration Charge of 10%	11,973	11,973	0
Total	**131,707**	**53,690**	**78,017**
Total Network Funds Remaining		***87,696***	