PMHA | PRIVATE MENTAL HEALTH ALLIANCE

NINTH MEETING

HELD ON

FRIDAY, 2 OCTOBER 2009

AT

ADELAIDE CLINIC
33 PARK TERRACE
GILBARTON
SOUTH AUSTRALIA

DRAFT REPORT AND RESOLUTIONS

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 Private Mental Health Alliance (PMHA), Independent Chair, Mr Philip Plummer, opened the Ninth (9th) Meeting of the PMHA (the Meeting) at 9:00 AM on Friday, 2 October 2009. The Meeting was kindly hosted by the Adelaide Clinic, 33 Park Terrace, Gilberton, in South Australia. The following representatives were in attendance.

1.	Mr Phillip Plummer	PMHA Independent Chair
2.	Ms Moira Munro	PMHA Deputy Chair and APHA Representative
3.	Ms Janne McMahon	PMHA Consumer Representative
4.	Dr Choong–Siew Yong	Australian Medical Association (AMA)
5.	Dr Bill Pring	AMA
6.	Ms Carole Turnbull	Australian Private Hospitals Association (APHA)
7.	Ms Helen Eriksson	Australian Health Insurance Association (AHIA)
8.	Mr Greg Kovacs	AHIA
9.	Ms Robyn Milthorpe	Australian Government Department of Health and Ageing (DoHA) Mental Health Reform Branch
10.	Mr Allen Morris–Yates	PMHA–CDMS Director
11.	Phillip Taylor	PMHA Director (Secretary)

1.1 Apologies

1.	Ms Ruth Carson	PMHA Carer Representative
2.	Mr Peter Callanan	DoHA Private Health Insurance Branch

2. Report of the last (Seventh) PMHA Meeting

The PMHA adopted the report of its last meeting.

Resolved (unanimous)

1. *That the Private Mental Health Alliance (PMHA) adopts the Report of the Eighth PMHA Meeting held on 22 May 2009 in Adelaide, as a true and accurate record of proceedings.*

2. *That the PMHA directs that the Report of the Eighth 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 8th PMHA Meeting.

TABLE OF PROGRESS	RESPONSIBILITY	STATUS
Agenda Item 2: PMHA Meeting Reports		
Post Report of 7th PMHA Meeting and PMHA Workshop on PMHA Website.	PMHA Director	Done
Draft and circulate for comment Report of 8th PMHA Meeting held on 22 May 2009.	PMHA Director	Done
Revise Report of 8th PMHA Meeting and prepare final.	PMHA Director	Done
Agenda Item 9th PMHA Meeting.	PMHA Director	Done
Agenda Item 4: AMA Financial Statements		
Carry forward surpluses in PMHA/CDMS/Network budgets into 2009–10	AMA	Done
Agenda Item 9th PMHA Meeting.	PMHA Director	Done
Agenda Item 5: PMHA–CDMS Management Committee		
Meet with DVA to discuss participation on the PMHA.	PMHA Director	*16 October 2009*
Dissolve Management Committee and incorporate into main PMHA Meeting.	PMHA Director	Done
Agenda Item 9th PMHA Meeting.	PMHA Director	Done
Agenda Item 6: Collaborative Care Models Working Group (CCMWG)		
Agenda Item 9th PMHA Meeting.	PMHA Director	Done
Agenda Item 7: Private Mental health Consumer Carer Network (Australia)		
Advise the AMA to proceed with the establishment of a static website for Network.	PMHA Director	Done
Agenda Item 9th PMHA Meeting.	PMHA Director	Done
Agenda Item 8: Mental Health Standing Committee Report		
Agenda Item 9th PMHA Meeting.	PMHA Director	Done
Agenda Item 8.4: National Mental Health Report Card (RC) for Australia		
Write to Chair of the MHSC outlining the concerns of the PMHA in relation to the RC.	PMHA Director	Done
Agenda Item 9: AMA Agreement for Services 2009–2012		
Revisit PMHA/CDMS/Network Budgets to see if any further savings can be made.	PMHA/CDMS Directors/Ms McMahon	Done
Finalise the AMA Agreement for Services pending advice from DoHA of funding period.	PMHA Director	Done
Agenda Item 10 PMHA Communications		
Agenda Item 9th PMHA Meeting.	PMHA Director	Done
Agenda Item 10.1 PMHA Newsletter		
Draft Third Edition of PMHA Newsletter for comment by PMHA Members.	PMHA Director	Done
Revise Newsletter based on comments received.	PMHA Director	Done
Publish Third Edition in July/August 2009.	PMHA Director	Done
Agenda Item 10.2 Fact Sheet		
Finalise Fact Sheet for Inclusion in Fourth Edition of PMHA Newsletter	PMHA and PMHA Director	*Pending*
Agenda Item 11.2 Transcranial Magnetic Stimulation (TMS)		
Agenda Item 9th PMHA Meeting	PMHA Director	*Pending*
Agenda item 13 Next PMHA Meeting		
Organise 9th PMHA Meeting for 2 October 2009 @ The Adelaide Clinic	PMHA Director	Done
Prepare and circulate Agenda and Papers for 9th PMHA Meeting	PMHA Director	Done

3.1 Meeting with the Department of Veterans Affairs' (DVA)

The PMHA Director, Mr Phillip Taylor, reported that a meeting has been arranged with DVA for Friday, 16 October 2009 at DVA headquarters in Canberra. The Meeting noted that the following representatives will attend.

1.	Mr Phillip Taylor	Private Mental Health Alliance
2.	Ms Robyn Milthorpe	DoHA Mental Health Reform Branch
3.	Dr Graeme Killer	Principal Medical Adviser DVA
4.	Mr Wayne Penniall	National Manager Community and Aged Care DVA
5.	Ms Joanne Krueger	Acting Director, Mental Health Policy, DVA

In response to Mr Taylor's request for clarification as to the purpose of meeting with DVA, the PMHA confirmed that the meeting was essentially to invite DVA to participate on the PMHA, as it had done so in the past on the PMHA's antecedent the Strategic Planning Group for Private Psychiatric Services (SPGPPS).

DVA was first invited to join the SPGPPS in November 2000 and held one vote. DVA was represented by Mr David Morton until June 2005, when he was succeeded by Mr Maurie O'Connor. During that time, the then Commonwealth Department of Health and Ageing held two positions on the SPGPPS with one vote each. This meant that the Australian Government effectively held a total of 3 votes on the SPGPPS from 2001 until the SPGPPS was restructured into PMHA at the end of 2006. The restructure resulted in the current situation whereby the Australian Government holds two positions on the PMHA each with one vote (2 votes).

If DVA wishes to accept the PMHA's invitation and nominate a representative to participate, then the Australian Government would essentially hold three positions on the PMHA. The Meeting felt that the alternative of Observer status for DVA would be tokenistic. There was consensus that a possible way forward would be for the current agreed voting rights for the Australian Government (2 votes) on PMHA to be retained, with it being left in the hands of the three Australian Government representatives to discuss and decide how those two votes would be caste on any particular issue. What is important is to have the three relevant areas of the Australian Government (DoHA's Mental Health Reform Branch, its Private Health Insurance Branch, and DVA) providing representatives to participate on the PMHA. Mr Taylor indicated that voting rights would be discussed at the meeting with DVA.

4. AMA FINANCIAL STATEMENTS

The Meeting discussed and adopted the AMA Statements of Income and Expenditure for the PMHA, its CDMS, and the Network, for the period 1 July 2008 to 30 June 2009, as they appear at **Appendix A** of this Report.

The Meeting noted that, as requested by the Parties to the *AMA Agreement for Services 2008–2009*, the surpluses in these budgets had been carried forward by the AMA into the respective income streams of the PMHA, its CDMS and Network for Financial Year 2009–2010,

Resolved (unanimous)

1. *That the PMHA adopts the AMA Statement of Income and Expenditure for the Private Mental Health Alliance, its Centralised Data Management Service, and the Private Mental Health Consumer Carer Network (Australia), for the period 1 July 2008 to 30 June 2009.*

2. *That the PMHA notes that the surplus of $14,989 remaining in the PMHA Budget for Financial Year 2008–2009 at 30 June 2009 has been carried forward into the Financial Year 2009—2010 PMHA income stream.*

3. *That the PMHA notes that the surplus of $27,898 remaining in the CDMS Budget for Financial Year 2008–2009 at 30 June 2009 has been carried forward into the Financial Year 2009—2010 PMHA—CDMS income stream.*

4. *That the PMHA notes that the surplus of $6,600 remaining in the Network Budget for Financial year 2008—2009 at 30 June 2009 has been carried forward into the Financial Year 2009—2010 Network income stream.*

5. PMHA PROGRESS REPORT 2008–09

Mr Taylor reported that a draft Progress Report for the PMHA, its CDMS and the Network, which had been circulated with the agenda and papers for this Meeting, had been prepared in consultation with the PMHA–CDMS Director and the Chair of the Network. The draft Report covers the period of the previous *AMA Agreement for Services 2008–2009*, which expired on 30 June 2009. KPMG will shortly conduct an audit of the PMHA, CDMS and Network accounts and copies of the KPMG letters of acquittal will then be attached to the Progress Report. Ms Robyn Milthorpe agreed to provide some material expanding on the work of MHISS for inclusion in the Progress Report.

Resolved (unanimous)

1. *That the Private Mental Health Alliance (PMHA) adopts the report titled, Progress Report: PMHA, PMHA's Centralised Data Management Service (CDMS), Private Mental Health Consumer and Carer Network (Australia) 1 July 2008 to 30 June 2009, and its statements of income and expenditure presented in Tables 7, 8 and 13.*

2. *That the PMHA directs that the Progress Report be forwarded to the Parties to the AMA Agreement for Services 2008–2009, and made available on the PMHA website at: www.pmha.com.au.*

Action: PMHA Director

6. PMHA WORK PLAN

Mr Taylor reported that at the 9 November 2007 meeting between PMHA stakeholders, it was agreed that future work plans for PMHA, its CDMS and the Network should be developed in detail on a financial year–to–year basis under an overarching conceptual framework of principles and priorities covering the three year period, 1 July 2008 to 30 June 2011. In accordance with that agreement, the PMHA

conducted a workshop on 27 March 2008 in Canberra to develop a program of work for the PMHA for the 2008–09 Financial Year period.

The Meeting then considered a copy of the agreed *PMHA Principles and Priorities for 2008–2011* and *Work Plan for 2008–09*, which had been circulated with the agenda and papers for this Meeting. It was agreed that the work plan should cover the period of the *AMA Agreement for Services 2009-2011* and be amended to take into account the following.

- The work of the PMHA identified in the *Work Plan for 2008-09* that is ongoing and needs to be carried forward into the *Work Plan for 2009-11*.
- The PMHA's participation in the work that is already underway at the national level that is directed toward achieving consistency in the provision of safe high quality mental health care.
- The ongoing work of the PMHA Collaborative Care Models Working Group.
- The incorporation of the role of the PMHA-CDMS Management Committee into the core business of the PMHA with teleconferences being held as required between face-to-face meetings of the PMHA to discuss issues relevant to the governance of the PMHA's CDMS.
- The need to ensure that the work of the PMHA Collaborative Care Models Working Group (PMHA–CCMWG) continues to open up discussion on:
    - innovative models of service delivery and their funding;
    - integration of different types of service delivery between the public and private sectors; and
    - the shift toward models of prevention and promotion.
- Participate in the development of uniform quality and safety provisions for models of service delivery that emerge under private health insurance legislation.
- Continue the examination models of funding and service delivery that are emerging outside of the Hospital setting.
- Conduct a PMHA Workshop toward the end of 2010 to discuss the future work programs and budgets for PMHA, PMHA–CDMS and Network and any areas of concern that need to be addressed in their development.
- Consider whether the PMHA should conduct a one-off forum and what costs might be involved.

Resolved (unanimous)

That the Private Mental Health Alliance (PMHA) requests that the PMHA Director develop a Work Plan for the PMHA for the two financial years 2009-11 based on the suggestions of the 9th PMHA Meeting held in Adelaide on 2 October 2009 for consideration at the next (10th) PMHA Meeting.

Action: PMHA Director

7. PMHA COLLABORATIVE CARE MODELS WORKING GROUP REPORT

In 2008–09, the PMHA expanded its structure to include a Collaborative Care Models Working Group (CCMWG) to accommodate the major stakeholder groups now comprising the private mental health sector. In addition to the existing groups represented by the PMHA (consumers and carers, psychiatrists, private hospitals, private health insurers, and the Australian Government), this new structure has enabled the PMHA to extend an open invitation for general practitioners (GPs), psychologists, mental health nurses, and allied health professionals to participate. At the request of the PMHA, its CCMWG has been working on the following tasks in 2009.

1. Development of a set of *General Principles for the Funding Private Mental Health Services* (Principles)

2. The review and update of the 2006 Discussion Paper *Underlying Principles for Funding Psychiatric Care*, (Discussion Paper) prepared by the PMHA's antecedent the Strategic Planning Group for Private Psychiatric Services.

3. The review and update of the 2007 Edition of the *Guidelines for Determining Benefits for Health Insurance Purposes for Private Patient Hospital–Based Mental Health Care* (Guidelines).

The CCMWG Chair, Mr Taylor, briefed the meeting on some changes that had been made to the Principles and progress with the review of both the 2006 Discussion Paper and the Guidelines. The Meeting noted that the next meeting of the CCMWG will be held on Friday, 27 November 2009, largely to complete the review of the Guidelines and to finalise the Discussion Paper. Mr Taylor anticipated that the Discussion Paper would be ready for publication in early 2010. The Guidelines may take longer to finalise, depending on the outcome of the next CCMWG meeting.

The Meeting discussed the lack of formal GP representation on the CCMWG. Dr Choong-Siew Yong explained that there are a range of organisations having difficulties with obtaining representation from the RACGP.

Mr Taylor reported that AAOT had undergone an internal restructure and would be able to provide a new representative for CCMWG in due course to replace Ms Heather Hudson, who resigned earlier this year.

Ms McMahon mentioned the work that had been done on the development of three new innovative models for inclusion in the Discussion paper that she hoped would stimulate debate when is released.

Resolved *(unanimous)*

1. *That the Private Mental Health Alliance (PMHA) adopts the Report of the Third Meeting of the PMHA's Collaborative Care Models Working Group (CCMWG) held on Friday, 19 June 2009 in Canberra and notes the draft Report of the Fourth CCMWG Meeting held on Friday, 11 September 2009 in Canberra.*

2. *That the PMHA endorses the following General Principles for Funding Private Mental Health Service Delivery as revised by the CCMWG.*

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:*
   - *Providers who work independently.*
   - *Providers who work in the public sector and private sector.*
   - *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.*
   - *The effectiveness with which the needs of consumers and their carers are met.*
   - *The efficiency with which the required services are able to be delivered.*
   - *The extent to which financial risk is equitably shared between providers and payers, or is controlled by other mechanisms.*
   - *Best medical practice and care, including suitability and risk assessment to themselves and to others.*

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.

- *The disease, syndrome or condition for which services are to be delivered should be a recognised psychiatric condition.*
- *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. Such models should include the following.

(a) Scope
(b) Purpose
(c) Conduct
(d) Independent Evaluation
(e) Intended Implementation

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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 criterion specifies that services should be modeled on what can be shown to be recognised by authoritative clinical consensus to be current best practice.*

8. PMHA'S CENTRALISED DATA MANAGEMENT SERVICE (PMHA–CDMS)

The Meeting adopted the draft *Report of the Eighth PMHA–CDMS Management Committee Meeting* (Report) held on 21 May 2009 in Adelaide and directed that the Report be made available on the PMHA website.

Resolved (unanimous)

That the Private Mental Health Alliance (PMHA) adopts the Report of the Eighth PMHA–CDMS Management Committee Meeting (Report) held on 21 May 2009 in Adelaide as an accurate record of the final meeting of the PMHA–CDMS Management Committee, and requests that a copy be posted on the PMHA website.

8.1 Governance of the PMHA-CDMS

The Meeting noted that at the end of the 22 May 2009 meeting of the PMHA, there was some consensus that to reduce duplication and costs, the role of the PMHA–CDMS Management Committee, should be incorporated into the PMHA meeting. After discussion, this Meeting ratified the role previously undertaken by the Management Committee, being incorporated into meetings of the PMHA as core business. It was further agreed that, similar to today's Meeting, all future PMHA meetings will be extended from 9:00 AM to approximately 5:00 PM to accommodate PMHA–CDMS reporting.

Resolved (unanimous)

That the Private Mental Health Alliance (PMHA) endorses the role previously undertaken by its PMHA-CDMS Management Committee, being incorporated into meetings of the PMHA as core business with future PMHA meetings being extended from 9:00 AM to approximately 5:00 PM to accommodate PMHA–CDMS reporting.

8.2 Risk Management for the PMHA's CDMS

The Chair raised the issue of what risk management strategies are in place for the PMHA's CDMS. The PMHA-CDMS Director, Mr Allen Morris-Yates provided a brief history of this issue and its current status, which has been summarised below.

- There is no written manual on how to operate the CDMS Data Warehouse. It is a bespoke database application and the end-to-end process is not documented. What is thoroughly documented are the requirements for data collection and submission. There is an old CDMS Operations Guide that was written to support the role the SPGPPS Administrative Officer (Ms Bronwen van der Wal) played in the production of Standard Quarterly Reports (SQRs). That "back-up" role was lost at the end of 2006 when the SPGPPS was restructured into PMHA and funding reduced to a level that precluded employment of an Administrative Officer from 2007 onwards. It would be possible for someone to work out the process for data collection and submission from that Guide. There is also documentation internally within the software to explain the program. The software could be loaded onto another machine and an experienced software developer should be able to understand how the program works.

- There is a database of Hospital and Health Insurer contacts maintained within the CDMS Data Warehouse. This must be kept up-to-date.

- There is a very detailed User Guide for the software that Hospitals use. If properly followed, Hospitals should not require any assistance.

- Despite the above, every Quarter somewhere between a quarter and one third of Hospitals need some assistance with preparing their data for submission.

- After each run of SQRs, a copy of the software used to generate those Reports is provided on DVD to the PMHA Director and this DVD is stored securely by the AMA. Together with that software, that DVD also contains all of the submissions Hospitals have ever made. The data contained on that DVD could be reloaded and a good developer should be able to determine how to re-run the SQRs.

- Unlike the HSMdb software used by Hospitals, which has been designed to be user friendly and robust in the face of incorrect usage, the CDMS software is not user friendly, nor is it robust to user input error. The software that underpins the CDMS Data Warehouse is always a work-in-progress, with changes made as required to produce, for example, different types of reports including the SQRs and the more recent CDMS Annual Statistical Report.

- At present, if the PMHA-CDMS Director were indisposed for some months, or more permanently, it is anticipated that the downtime would be contingent on how quickly the AMA would be able to undertake the following tasks.

  1. Purchase and configuration of a server able to run the software.

  2. Finding an appropriate developer to install the CDMS Data Warehouse software onto the new server.

  3. Determing how the software works.

  4. Retrieving all submissions made by Hospitals since the last back-up was supplied to the AMA.

  This work would only enable the restoration of processing of the data submitted by Hospitals and the generation of SQRs for Hospitals and Health Insurers. Other more complex work undertaken by the CDMS, such as updating the HSMdb software when it expires and providing the new version to Hospitals, would take a longer period of time.

- There is currently no insurance for the PMHA's CDMS to fund any worst case scenarios. The Key Man insurance that was part of the previous risk management strategy for the CDMS was not renewed to reduce costs.

The Meeting then discussed the current situation and agreed that the development of a Disaster Recovery Plan should be included in the work plan for the PMHA's CDMS for 2009-2011. There was consensus that the most appropriate site for Disaster Recovery to take place would be at the offices of the Federal AMA in Canberra, under the supervision of the PMHA Director and the AMA.

Resolved (unanimous)

That the Private Mental Health Alliance (PMHA) requests that the development of a Disaster Recovery Plan for the PMHA's CDMS be included in the work plan of the PMHA-CDMS for 2009 to 2011.

Action: PMHA-CDMS Director in consultation with PMHA Chair

8.3 PMHA-CDMS Director's Report

The PMHA then invited Mr Morris-Yates to report on progress with the current activity of the PMHA's CDMS.

8.3.1 Annual Statistical Report

Mr Morris-Yates discussed the final version of the Annual Statistical Report for the 2007–2008 Financial Year with the Meeting. This final version includes additional material and significant revisions consistent with the suggestions made by 22 May 2009 CDMS Management Committee meeting. The current version has been reviewed and approved for release by PMHA Hospital representatives Ms Moira Munro and Ms Carol Turnbull, and the chair of the APHA Psychiatric Hospitals subcommittee, Ms Christine Gee. After discussion, the PMHA endorsed the report as follows.

Resolved (unanimous)

That the Private Mental Health Alliance (PMHA) endorses the Annual Statistical Report on Private Hospital–based Psychiatric Services 1 July 2007 to 30 June 2008 (Report), prepared by the PMHA's Centralised Data Management Service, and requests that the PMHA Director co-ordinate release of the Report electronically via the following methods and, where necessary, in hard copy (HC) undercover of appropriate correspondence from the PMHA Chair.

- *PMHA Press Release*
- *PMHA Newsletter*
- *PMHA Website*
- *CEOs of participating private hospitals*
- *Chair of MHISS (HC)*
- *Chair of MHSC (HC)*
- *Chair of SQPS (HC)*
- *Director of AHIW (HC)*
- *Chief Executive Officers of APHA, AHIA, AMA, and Health Insurers (HC)*

Action: PMHA Director

8.3.2 Report on COAG Indicators 5 and 6

On 9 September 2009, the Chair of the Mental Health Information Strategy Subcommittee, Dr Aaron Groves, wrote to the Chair of the PMHA requesting that the PMHA's CDMS provide data for the COAG Annual Report. The CDMS undertook the necessary analyses and prepared a formal report for the Australian Government, which was provided to their representative on 16 September 2009. A copy of Dr Grove's letter to the PMHA and the Report subsequently provided by the Director of the CDMS to the Australian Government were noted. Mr Morris-Yates explained the basis for the estimates that were provided to Dr Groves.

8.3.3 Revision of the National Model the National Model for the Collection and Analysis of a Minimum Data Set with Outcome Measures (National Model)

The PMHA's CDMS has prepared two papers regarding revisions to the National Model, which had been circulated with the Agenda and Papers for this Meeting. The first titled, *Revision of the stratification framework used in Hospitals' and Payers' Standard Quarterly* Reports, addresses the stratification scheme used in the PMHA's CDMS Standard Quarterly Reports (SQRs). The second titled, *Reporting Framework, Version 3–0*, details a new version of the framework for the content and layout of SQRs.

- ***Revision of the stratification framework used in Hospitals' and Payers' Standard Quarterly Reports***

  This first paper discusses changes to the diagnostic classification used in the stratification of statistics in both Hospitals' and Payers' SQRS. The recommendations include that the classification be simplified to remove rarely occurring diagnostic groupings from reports; rename certain of the major groupings to improve the accuracy with which they identify the diagnoses covered by the group; and the inclusion of two clinical co–morbidity groups. The revised classification is as follows: (0) All patients regardless of Principal or Secondary Diagnosis; (1) Schizophrenia, Schizoaffective and Other Psychotic Disorders; (2) Major Affective and Other Mood Disorders; (3) Anxiety Disorders; (4) Post-Traumatic Stress & Other Adjustment Disorders; (5) Personality Disorders; (6) Alcohol or Other Substance Use Disorders; (7) Eating Disorders; (8) All Patients with Co–morbid Personality Disorder; and (9) All patients with Co–morbid Alcohol or Other Substance Use Disorder.

  Mr Morris-Yates discussed the revised categories and reported on the difficulties in dealing with the additional classification for *Co-morbid Significant Medical Conditions*. Discussions are underway with the area of DoHA that has responsibility for this ARDRG classification and the Meeting noted the list of questions submitted by DoHA to Mr Morris-Yates. It is anticipated that DoHA will eventually be able to provide the necessary information.

  Hospitals have indicated that they are satisfied with the revised classification.

  In reading through this first paper Ms Helen Eriksson and Mr Greg Kovacs did not see any particular issues for Health Insurers, at this stage.

- ***Reporting Framework Version 3***

Mr Morris-Yates then explained this second paper, which details the proposed new formats for both Hospitals and Payers SQRs. The objective of the revisions is to substantially improve both the accessibility and content of the SQRs without obscuring the inherent complexity of the problems for which care is provided. Version 3 will effectively collapse the SQRS substantially and report on the more statistically relevant variations that are detected. The full detailed statistics will still be retained in the XML Data Extracts provided to Hospitals and Health Insurers for their use.

This second paper also includes a detailed discussion of the issues involved in reporting on Ambulatory Care and proposes a new episode–based model of reporting Ambulatory Care that should meet both Hospitals and Payers needs. This will be a substantial advance in what Hospitals are currently receiving. A detailed discussion then took place on the difficulties of defining Episodes of Ambulatory Care, particularly those that take place outside of the hospital-based setting.

The Meeting agreed that the process for reviewing and finalising this document should begin with Mr Morris-Yates presenting this paper to the members of the APHA Psychiatry Committee and the AHIA Mental Health Committee. It was agreed that the representatives on those Committees will be responsible for disseminating the information to their respective constituencies for comment.

Resolved (unanimous)

That the Private Mental Health Alliance (PMHA) requests that the APHA Psychiatry Committee and the AHIA Mental Health Committee arrange to meet with Mr Allen Morris-Yates in Adelaide to discuss the document titled, Reporting Framework Version 3, prepared by the PMHA's Centralised Data Management Service.

Action: Ms Munro/Ms Turnbull/Ms Eriksson/Mr Kovacs

8.3.4 Progress with re–development of the CDMS data warehouse software

Since May 2009, work on the re–development of the data warehouse has been focussed on re–factoring and porting what are known as the Extract–Transform–Load (ETL) processes to the new data warehouse platform (MS SQL Server 2008 running under MS Windows Server 2008). These processes take the data submitted by Hospitals and transform it into records suitable for analysis. The ETL processes assemble records of Episodes of Care by linking together the OMP and HCP data submitted by Hospitals. During that process HoNOS and MHQ–14 Summary Scores and indicators of Co–morbidity are computed. Once individual episodes have been assembled, each patient's set of episode records are scanned in order to compute indicators of Re–admission, Problem chronicity and other sequential relationships for each episode. Due to inconsistencies and omissions in the data provided by Hospitals the actual process is somewhat more complicated than it otherwise might be. An initial pass over the data is used to prepare a set of records within which simple errors and inconsistencies have been corrected and duplicates removed. A second pass

across that corrected set of records then prepares a set of linked records for each patient. The inconsistencies and omissions revealed by the linkage process are then identified and where possible corrections are made to a copy of the submitted data. The episodes are then re–assembled using that corrected data set as the basis. After each new data submission is received from a hospital this process is repeated to ensure that any corrections evident in the new submission are carried through into the final data subjected to analysis.

Mr Morris-Yates reported that porting of the above quite complex set of SQL scripts and associated functions has been somewhat complicated by the fact that the existing data warehouse software is written in different dialects of SQL and VB to that used within MS SQL Server 2008. Whilst slowing the work somewhat, the need to translate almost all the existing code has provided an opportunity to review and improve the whole ETL process.

8.3.5 Development and distribution of a revised version of the HSMdb database application

The Meeting noted that the revised version (1–710) of the HSMdb data application was prepared and distributed in mid July 2009 to all participating Hospitals. Most revisions included in this new release were to correct problems identified by users in HSMdb's internal functions and processes. Few changes were made to the actual user interface. There were two exceptions. First, the recently revised version of the MHQ–14 scoring algorithm, which employs the much simpler algorithms specified by the original developers of the questionnaire (the Rand Corporation) to generate the four summary scores and an MHQ–14 Total Score defined by the CDMS, was built into the software. The local reports able to be generated from within HSMdb now also include the revised MHQ–14 Summary and Total Scores. Second, at the request of users, the patient record deletion function was moved away from the routine data entry interface into a dedicated data correction menu that also includes a duplicate patient record merge function.

8.3.6 Revision of the SQR Viewer application for Payers

The SQR Viewer was first provided to all Payers on the SQR Distribution CD in October 2008. A revised version of the SQR Viewer was prepared in September 2009 and will be distributed to Payers with the next round of SQRs, due out in early October 2009. Following the initial release of the Viewer, users made some comments regarding the formatting of the comparative reports the viewer made available. Changes have been made in accordance with those comments, which should enhance the usability of the historical data included in the printed reports. Also, problems experienced by one particular Payer due to the complex nature of their relationship with their Payer Group, have been partially corrected. Complete correction of the problem must wait on the revision of the aggregate statistical data cubes on which the SQRs are based.

8.3.7 Re–enrolment of Healthscope hospitals and enrolment of other new facilities

In the last quarter of the 2008–09 Financial Year and the first quarter of the 2009–10 Financial Year, sixteen Hospitals enrolled in the PMHA and its CDMS. Of those, 12 were re–enrolling Hospitals whilst the remainder were new enrolees. They are listed

below, together with the dates on which the Director of the CDMS visited the new enrolees to provide face–to–face training. (Note also that, as per the old agreement for new enrolees prior to 2009, a second site visit was provided to Sentiens Clinic in Western Australia on 19 June 2009).

1.	Brisbane Private Hospital (Brisbane,		
2.	Brisbane Waters Private Hospital (Woy	New	visited on 9th July
3.	Campbelltown Private Hospital	New	visited on 28th July
4.	The Geelong Clinic (St Albans Park,		
5.	Malvern Private Hospital (Malvern East,	New	visited on 23rd September
6.	The Melbourne Clinic (Richmond, VIC)		
7.	Mitcham Private Hospital (Mitcham, VIC)	New	visited on 7th August
8.	Mosman Private Hospital (Mosman,		
9.	Niola Private Hospital (West Leederville,	New	visited on 17th August
10.	North Eastern Rehabilitation Centre	New	visited on 29th July
11.	Northpark Private Hospital (Bundoora,		
12.	Pine Rivers Private Hospital (Strathpine,		
13.	St Helens Private Hospital (Hobart, TAS)		
14.	The Sydney Clinic (Bronte, NSW)		
15.	Sydney South West Private Hospital		
16.	The Victoria Clinic (Prahan, VIC)		

All sixteen new and re–enrolling Hospitals have also been provided with complete packages of Training and Reference Materials and copies of the latest version of the HSMdb database application. So far, two of the new Hospitals have been able to submit data for the current Quarter.

8.3.8 Hospitals progress with implementation of the National Model

The Meeting noted a copy of the *Report from the PMHA's Centralised Data Management Service regarding progress by participating Hospitals in their implementation of the National Model* that was provided for Mental Health Information Strategy Sub–committee (MHISS) for their last meeting. The Meeting discussed the Report, which plots Hospitals progress with collection of outcome measures since data was first submitted to the CDMS by Hospitals in late 2001.

Some of the rare consequences that might be experienced by a consumer completing instruments such as the MHQ-14 were briefly discussed, such as the risk of women reporting a suicidal ideation having their children removed from their care. The Meeting agreed that completing such instruments is usually a voluntary undertaking. In the case of MHQ-14, the consumer is free to decline completing the questionnaire.

8.3.9 Standard Quarterly Reports (SQRs).

The last SQRs were despatched on 6 May 2009 to Hospitals and Health Insurers. That SQR run was delayed for one month due to one large Hospital revising its Patient Administration System (PAS) system. There may be some delay with the next SQR run while Healthscope are brought back on line.

8.4 Enabling greater use of the data held by the CDMS.

The Chair opened this agenda item by clarifying the nature of the anonymous offer that has been made of financial support. Essentially Mr Plummer must ensure that this financial support is directed towards work where a measurable improvement in client mental health can be demonstrated. Whilst the exact quantum of funding has not yet been finalised, it will be something of the order of $250,000 that may be made available before June 2010. Given the PMHA-CDMS appears to be that part of the PMHA's business that is most easily able to demonstrate such improvements, Mr Plummer requested, Mr Allen Morris–Yates, prepare the brief Discussion Paper titled, *Strategies for enabling greater use of the data held by the PMHA's Centralised Data Management Service*.

At its 22 May meeting of the PMHA it was agreed that the Discussion Paper needed to be recast into a project brief that enabled Hospitals, Health Insurers and psychiatrists to make better use of the CDMS data in a way that gives something of value back to the stakeholders who have invested in the PMHA and its CDMS. At that time it was felt that the brief needed to be focussed on the positive outcomes and additional enhancements that could be achieved for these stakeholders. In particular, improving current reporting and enabling easier and more comprehensive access through a secure web–based interface, are important issues that would add value to what is currently proposed. How workload issues and the risks involved are to be managed to prevent the normal work schedule of the CDMS from being compromised was critically important to all stakeholders. At the 22 May meeting, stakeholders agreed to consult their constituencies and report back to this Meeting with their suggestions.

Mr Kovacs reported that the AHIA Mental Health Committee has considered this matter and supports the funding being directed toward the work of the PMHA's CDMS. It is the best area where industry data can be used to affect clinical best practice and research to improve patient care.

Ms Munro reported that the APHA Psychiatry Committee has also considered this matter and supported improving access to the CDMS through a secure web–based interface as a positive measure. The Meeting noted that Health Insurers also supported this suggestion. The other suggestion put forward, was to use some of the funding to undertake a project to implement the national collection of the consumer perceptions of care measure across Hospitals. The Consumer Perceptions of Care Project (CPoC) has now demonstrated the feasibility of implementing the measure and it is gaining increasing recognition for use on a national basis. This would enable benchmarking of not only clinical outcomes of care but consumer satisfaction, which would benefit both the Hospitals and consumers and carers. APHA acknowledged that the Clinical Research Network was also a good idea, if it could be done in such a way as to not compromise the normal work of the CDMS. Ms Munro felt that while the

APHA may be able to further develop these suggestions, input from Mr Taylor and Mr Morris-Yates would be required on costings and any other relevant matters.

Dr Pring reported on a suggestion for a project he was developing for circulation and consideration by other members of the PMHA. Essentially, this project would involve a small group of Hospital-based psychiatrists looking at perhaps 10 patients for each psychiatrist. A cohort of the high Hospital and Health Insurer utiliser patient group would be included, together with another group that the psychiatrists would do outcome measures for in their private practice, with the intention that the two sets of data could be combined. Half of the patients would have a program of the psychiatrists using the outcome measurement data with the patients, and the other half would not. The quantitative data could then be compared and contrasted. A qualitative assessment of the experiences of the psychiatrists and patients involved could also be undertaken.

Ms Milthorpe reported on discussions with Ms McMahon concerning DoHA funding a project to implement carer resources as an outcome of the Identifying the Carer Project. Ms Milthorpe anticipated that DoHA will be able to partially fund this project and asked that consideration be given to some of the available funding being directed toward this project. The Meeting noted that the project would result in the implementation of clinical practice guidelines and resource materials across the public and private sectors, directed at better engagement of cares. Ms Milthorpe will consult with Ms Turnbull and Ms Munro concerning what is already being done in this area in private hospitals.

8.4.1 Way Forward

The Meeting then discussed the range of suggestions put forward today. Mr Plummer indicated that before the end of June 2009, he would require a brief overarching proposal that clearly sets out what projects might be able to be undertaken and the estimate overall costs involved. In terms process, the Meeting clarified that following tasks now need to be undertaken before the first meeting of the PMHA in 2010.

Resolved (unanimous)

That the Private Mental Health Alliance (PMHA) recommends that the following steps be undertaken toward the development of an overarching proposal for the use of the anonymous offer of approximately $250,000 of financial support made by the PMHA Chair toward work that can be undertaken where a measurable improvement in mental health can be demonstrated.

(a) Ms Moira Munro, Dr Bill Pring and Ms Janne McMahon develop further their respective proposals for utilising a proportion of this funding, in consultation, where necessary, with the PMHA-CDMS and PMHA Directors, and any other relevant colleagues or organisations.

(b) Ms Munro, Dr Pring and Ms McMahon then meet via teleconference, as a sub-committee of the PMHA, to determine their priorities within the context of the available funding.

Action: Ms Munro/Dr Pring/Ms McMahon

8.5 Reporting of Information on Charges in Hospitals SQRs

The Meeting considered a copy of the correspondence received from Ms Gaylyn Cairns, National Manager Psychiatry, Healthscope Limited, in early July 2009 togther with a copy of the email from the PMHA's CDMS Director to which Ms Cairns refers to in the first paragraph of her letter. In the absence of the PMHA Chair overseas, a copy of Ms Cairns letter and the associated email from the CDMS Director was provided to the PMHA Deputy Chair by email on 7 July 2009. Ms Munro explained that this matter had now been resolved and Ms Cairns reassured that the financial information that is routinely reported in Table 4.1 of the SQRs for Hospitals is not provided to Health Insurers. Ms Munro and Ms Turnbull have made themselves freely available to Ms Cairns should there be any further queries regarding this matter.

Mr Morris-Yates then responded to several questions and clarified what is currently provided in SQRs and what may be provided in the new version of the SQRs in relation to the financial information for both Hospitals and Health Insurers.

8.6 Consumer Perceptions of Care (CPoC)

In December 2005, an *AMA Agreement for Services*, between the AMA, DoHA and Queensland Health, was signed to enable a pilot study of *NRI/MHSIP Inpatient Consumer Survey* (CPoC Pilot Study) to be undertaken in both the private and public sectors in 2006. The collection phase of CPoC was completed in both the private and the public sectors in 2006. The following reports were due to be provided by 31 December 2006.

- A draft aggregate report for private hospitals for consideration by the APHA Psychiatry Sub–committee.
- A draft aggregate report for Queensland Health.
- A report for the Australian Government.

Ms Munro briefed the Meeting on progress with this matter and reported that Queensland Health are about to publish their final report. There is still no report for the private sector. Mr Morris-Yates indicated it would take a minimum of two weeks to complete a private sector report. The Meeting agreed that this work should be undertaken, as soon as possible, so it is available for the 19/20 November 2009 meeting of MHISS. The report should be released in the Public domain via PMHA Press Release and made available on the PMHA Website.

Resolved (unanimous)

That the Private Mental Health Alliance (PMHA) requests that the PMHA-CDMS Director undertake the necessary work to complete a final report for the private sector on the pilot study of NRI/MHSIP Inpatient Consumer Survey (CPoC Pilot Study) before 19/20 November 2009.

Action: PMHA–CDMS Director

8.7 Australian Institute of Health and Welfare (AIHW) Request

The Meeting considered the request from the AIHW that PMHA agree to contribute data relating specifically to indicator 21, Treatment Rate for Mental Illness, of the inaugural National Healthcare Agreement Performance Indicators Report to be prepared by the COAG Reform Council for COAG in 2010. After discussion, the Meeting agreed to provide the data. Mr Morris-Yates reported on the time it would take to extract the data in the required format. This would require the next run of SQRs for Hospitals and Health Insurers to be delayed in order to meet the AIHW 16 October 2009 deadline for data submission.

Resolved (unanimous)

That the Private Mental Health Alliance (PMHA) requests the PMHA Director advise the Australian Institute of Health and Welfare (AIHW) that PMHA agrees to contribute data for the National Healthcare Agreement Performance Indicators 2007-08 Report. The PMHA-CDMS Director is asked to undertake the necessary work to provide the data to the AIHW by its deadline of 16 October 2009.

Action: PMHA–CDMS Director

8.8 CDMS Work Plan 2009-11

Earlier in proceedings, the Meeting had considered a copy of the document titled, *Tasks to be undertaken by the PMHA's CDMS during July 2009 to June 2011*, which had been circulated with the agenda and papers for this Meeting. At that time, Mr Morris Yates explained the document had been prepared based on the experience of the past Financial Year by the CDMS Director to help to inform discussion of what PMHA's CDMS Stakeholders (DoHA, APHA and AHIA) would like to see included in the work program for the PMHA's CDMS for Financial Year 2009–10. The document included the following ongoing core responsibilities of the PMHA's CDMS, which are more fully articulated in Schedule A, Section 3.1 of the new *AMA Agreement for Services 2009–2011*.

1. Preparation of SQRs for Hospitals and Payers;

2. Revision of the National Model's Analysis and Reporting Framework.

3. Revision of the HSMdb database applications

4. Provision of electronic training materials for Hospitals

Earlier today, the Meeting also had discussed the document provided by Mr Morris-Yates and agreed that the final schedule of tasks to be incorporated into the CDMS work plan for 2009-11, should be determined after discussion of all the Agenda Items related to the CDMS had been completed.

The work agreed by this Meeting to be undertaken by the PMHA's CDMS within the context of its current budget is, therefore, summarised in the Resolution below.

Resolved (unanimous)

That the Private Mental Health Alliance (PMHA) requests that the following be included in the PMHA-CDMS Work Plan for Financial Years 2009-11.

Core Tasks (ongoing)

1. *Preparation of SQRs for Hospitals and Payers.*
2. *Revision of the National Model's Analysis and Reporting Framework.*
3. *Revision of the HSMdb database applications.*
4. *Provision of electronic training materials for Hospitals.*

Additional Tasks (in order of priority)

1. *Contribute data for the National Healthcare Agreement Performance Indicators 2007-08 Report by 16 October 2009.*
2. *Complete the final report for the private sector on the pilot study of NRI/MHSIP Inpatient Consumer Survey (CPoC Pilot Study) before 19/20 November 2009.*
3. *Develop a PMHA-CDMS Disaster Recovery Plan by the end of 2009 for consideration by PMHA at its first meeting in 2010.*

Action: PMHA–CDMS Director

9. PMHA COMMUNICATION

PMHA Communication is an ongoing Standing Item on the PMHA Agenda not only for discussion of issues related to the PMHA Newsletter, but also to consider what other strategies might be used to beyond the Newsletter to promote the private sector.

9.1 PMHA Newsletter

The Meeting noted a copy of the Third Edition of the PMHA Newsletter, which had been circulated with the agenda and papers for this Meeting, together with a copy of a draft Fact Sheet. Members endorsed the Fact Sheet for inclusion in the next (Fourth Edition) of the Newsletter, which is due for publication in December 2009.

Resolved *(unanimous)*

That the Private Mental Health Alliance (PMHA) requests that the PMHA Director draft the Fourth Edition of the PMHA Newsletter for circulation to members of the PMHA for comment.

Action: PMHA Director

9.2 Other Strategies

The Meeting endorsed the use of new signage for the PMHA newsletter and letterhead, that would print much more legibly on both colour and black and white printers.

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

The meeting noted a copy of the self–explanatory report of the last meeting of the Network, which was held on 17/18 August 2009 in Melbourne. The Chair of the Network, Ms Janne McMahon, briefed the Meeting in detail on submissions and Network activity.

The Meeting noted that the Network is starting to address succession planning and has appointed a Deputy Chair, Ms Kim Werner, who is a consumer with a legal background. The Network is also developing:

- a set of Operating Guidelines and Position Descriptions for personnel;
- position statements on smoking in inpatient units and payment for participation and recruitment; and
- three pamphlets on private health insurance, inpatient admission, and private hospitals.

Ms McMahon expressed her gratitude to the AMA for including the Network's personnel and its State Coordinators under the AMA's Professional Indemnity and Directors and Officers insurances.

The Network is approaching high profile people who may be interested in becoming Patron's for the Network.

There have been ten recent Network submissions including one on suicide. The Network also recently meet with Dr Meredith Arcus who is an adviser to the Federal Minister for Health and Ageing. The purpose of the meeting was to discuss further progress with the issue of borderline personality disorder.

The Network has agreed a work plan for Financial Years 2009-11 and is actively participating in the work of the PMHA's CCMWG and the RANZCP.

Resolved (unanimous)

That the Private Mental Health Alliance (PMHA) notes the Report of the meeting of the National Committee of the Private Mental Health Consumer Carer Network (Australia) held on 17/18 August 2009 in Melbourne.

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 last meeting of the MHSC was held in Sydney on Friday, 18 September 2009. The PMHA Chair and Deputy Chair both attended that meeting and reported verbally on some of the matters that are being progressed by the MHSC, which have been summarised below.

11.1 Fourth National Mental Health Plan 2009–2014

The Fourth National Mental Health Plan was endorsed by AHMC on 4 September 2009. The Commonwealth is progressing the editing and typesetting of the Plan towards a possible launch at the next AHMC meeting on 13 November 2009 in Adelaide. Priority area 5 and relevant aspects of priority 4 have been referred to MHISS for advice. MHSC has established an implementation strategy writing group.

11.2 COAG National Action Plan for Mental Health (2006-2011) Second (2nd) Progress Report 2007-08

The 2nd Annual COAG Progress report was endorsed at the AHMC meeting on 4 September 2009. The report will now be forwarded to COAG for consideration with the aim of public release.

11.3 National Advisory Council on Mental Health (NACMH) Report Card on Mental Health

MHSC have provided feedback on the NACMH paper titled, *A National Mental Health Report Card for Australia*'. This is intended to be the first of a series of papers intended to outline a framework for the development of a new system of accountability for mental health in Australia with the aim of driving reform and building public confidence in the mental health system. In providing their feedback, MHSC stated:

> *The private sector is largely ignored in the Report Card, which is particularly concerning given the level of activity taking place. Some examples of that activity are set out below:*
>
> 1. *The outcome measures being collected and reported on by the PMHA's CDMS since 2001(see Attachment 1 at the end of this document).*
>
> 2. *The ACHS accreditation process of private hospitals with psychiatric beds, and its more recent accreditation of some of those facilities against the National Standards for Mental Health Services.*
>
> 3. *The Australian Commission for Safety and Quality in Health Care (ACSQHC) is working on a project with the APHA to develop a suit of quality indicators for national benchmarking across hospitals, which include indicators for mental health. It is anticipated about 200 private hospitals will be involved.*

In their General Comments MHSC stated:

> *The scope of the Report Card paper could have been broader, for example:*
>
> *It does not recognise the significant role of the private sector in information systems development, data collection, analysis and reporting. It seems to reflect a limited interest in state and territory reporting. Any proposed national reporting framework should incorporate the full range of key stakeholders with an interest in this subject.*

11.4 Seclusion and Restraint

As part of the update on the activities of the Safety and Quality Partnership Sub-Committee (SQPS), the SQPS Chair, Dr Peggy Brown, mentioned Ms Janne McMahon's input into the work on seclusion and restraint. SQPS is looking at doing a survey of Emergency Departments with respect to their use of restraint and also including an optional indicator for Emergency Department staff who are trained in de-escalation. Ms McMahon then briefed PMHA on the background to this concerning issue. Ms Munro asked Mr Taylor to check whether the materials developed during the Seclusion and Restraint Project could be forward to the PMHA for information.

11.5 Mental Health Workforce Advisory Committee (MHWAC) Report

MHWAC last met on 23 July 2009 and will hold its next meeting on 15 October 2009. Ms Carol Turnbull will attend that meeting for the PMHA. PMHA noted that MHWAC activity is focussed on the following.

- National Practice Standards for the Mental Health Workforce Implementation Project. This project focussed on implementation of the standards in adult acute inpatient units and has concluded.
- Developments in national health workforce, including establishment of the national agency.
- Development of a National Mental Health Workforce Strategy and Plan.
- Web-based Professional Education Project (MHPOD)
- Mental Health Nurse Education Taskforce (MHNET)

11.6 National Hospitals and Hospitals Reform Commission (NHHRC) Report

The Australian Government is using the recommendations of this report as a basis for direct consultation with the health sector and the Australian public between now and the end of the 2009. The Government will also convene a special COAG meeting with the States and Territories in late 2009, explicitly on health and hospitals reform. Many of the 12 recommendations for mental health from the final report are consistent with the priority areas and action items from the Fourth National Mental Health Plan.

11.7 National Perinatal Depression Initiative

The National Perinatal Depression Initiative (NPDI) Framework was endorsed by AHMAC on 19 June 2009. All aspects of the NPDI are operating well and to schedule. Perinatal Depression specific psychological services are being well received and utilised through Divisions of General Practice under the Access to Allied Psychological Services funding. Beyondblue are working well in supporting the Commonwealth and States and Territories through the NPDI and have produced a number of valuable resources for both communities and professionals. DoHA is working towards determining additional avenues for outcome data collection. Ms McMahon mentioned there has also been a television documentary on this issue.

11.8 Meetings of the MHSC 2009-10

At the time of writing, the MHSC had amended its meeting schedule as follows for the remainder of 2009 and 2010.

1. Monday, 23 November 2009 Melbourne
2. Friday, 26 February 2010 Sydney
3. Friday, 14 May 2010 Brisbane
4. Friday, 17 September 2010 Melbourne

Mr Plummer reported that he would be unable to attend the 23 November 2009 MHSC meeting. Dr Bill Pring agreed to attend as a proxy for Mr Plummer. Ms Munro will attend as the PMHA Observer.

Resolved (unanimous)

That the Private Mental Health Alliance (PMHA) requests that Dr Bill Pring attend the 23 November 2009 meeting of the Mental Health Standing Committee as a proxy for the PMHA Chair, who will be unable to attend.

Action: Dr Bill Pring

12 MHSC SQPS REPORT

The SQPS is responsible for taking the Australian Government mental health safety and quality agenda forward. While the Australian Commission for Safety and Quality in Health Care (ACSQHC) leads the national effort to improve the safety and quality of health care provision in Australia generally, the SQPS has a defined focus on safety and quality in mental health care. It is intended that the SQPS and the ACSQHC work in partnership. The SQPS brings together key stakeholders in the mental health field, from both the public and the private sectors that are relevant to implementation of national priorities. The PMHA is represented on the SQPS by Dr Bill Pring. Dr Pring reported on the following issues that were discussed at the most recent meeting of the SQPS, which was held in Darwin on 16/17 July 2009.

12.1 National Standards for Mental Health Services.

In May 2008, the Steering Group for the review of the National Standards for Mental Health Services (Standards) accepted the final Report and draft revised Standards. A national forum to review the revised Standards and to discuss issues relating to

implementation was held in October 2008. At that forum, the vast majority of the mental health service representatives supported the revised Standards including the Recovery Standard, noting that the latter is consistent with state, territory and national mental health policy. Following the forum, SQPS was advised that some consumers, carers and community agencies were seeking further consultation in relation to the Recovery Standard in view of the limited exposure and consultation on this Standard. As a result, SQPS conducted a further targeted consultation on the Recovery Standard, which closed on 31 July 2009.

A National Standards Implementation Steering Committee (NSISC) has been established to oversee the significant work required to prepare for implementation of the Standards. It has established seven working groups to assist in the preparation work. NSISC met via teleconference on 8 and 11 September 2009 to finalise the draft Recovery Standard, which was circulated to SQPS members for out–of–session endorsement. All of the other revised Standards have previously been approved by SQPS. The Standards are being considered by the MHSC for endorsement out–of–session.

The objective of all this work is to most effectively implement the Standards. In the past, the most effective method in the private sector has been to have the Standards mandated through accreditation, which then creates a level playing field.

12.2 Seclusion and Restraint Working Party (SRWP)

While the Beacon Demonstration Project concluded on 30 June 2009, SQPS will continue to have a watching brief on the wider progress of the implementation of seclusion and restraint reduction initiatives nationally. At the conclusion of the National Documentation Project, a report on progress and recommendations was submitted to the Department of Health and Ageing as part of the 2008/09 funding agreement. SQPS intends to publish a comprehensive final report on the full two years of the project. The draft is expected to be considered at the November SQPS meeting for agreement to submit to MHSC for endorsement. The following draft suite of documents for the reduction of seclusion and restraint in public mental health services has been produced.

- Preamble to the documentation prepared by the Seclusion and Restraint Working Party.
- Seclusion Definition.
- Restraint Definition.
- Key Principles for Seclusion Practices.
- Key Principles for Restraint Practices.
- Procedures for Managing Episodes of Seclusion.
- Procedures for Managing Episodes of Restraint.
- Seclusion Practices Audit Tool.
- Restraint Practice Audit Tool.
- Core Training and Education principles, priorities and elements for the reduction of seclusion and restraint.

- Six Core Strategies for the reduction of seclusion and restraint in Australian mental health services.

It is intended for the documents to be published and released for use in Australian public mental health services.

The SQPS Chair, Dr Peggy Brown, has also participated in meetings with the Australian Private Hospitals Association and ACHS Emergency Department Clinical Indicators Working Group in relation to further work on the use of seclusion and restraint in Emergency Departments.

12.3 Safe transport of people with mental health problems

South Australia and the Northern Territory continue to develop a project relating to air transportation of persons with a mental illness. The next steps are to further scope the current level of air transport for mental health consumers including adverse incidents and issues and to review current air transport guidelines that impact on this. Jurisdictions will be asked to provide information in relation to this.

12.4 Reducing Adverse Medication Events in Mental Health Services

This is progressing and the MHSC has endorsed the Reducing Adverse Medication Events Working Party Framework. The Framework has been forwarded to the Australian Council on Safety and Quality in Health Care.

12.5 Reducing Suicide and Deliberate Self Harm in Mental Health Services

SQPS has discussed the issue of suicide prevention and the role of follow–up after discharge from mental health facilities and also in hospital environments where collateral information and the views of families/carers are often not heard, or not taken into account. As well as an indicator development issue, the SQPS Chair has agreed to look at taking this up as a piece of work around guidelines and how to give carers' needs a broader national focus. This is in conjunction with the work of the new National Council on Suicide Prevention.

12.6 Linkages with MHISS

Ms Milthorpe reported that SQPS is exploring greater linkages with MHISS to facilitate access to technical expertise and advice in this area. This was discussed at the recent MHISS meeting and the Chairs and Secretariats of the Subcommittees are liaising regarding a combined meeting of the SQPS and MHISS Members in November 2009.

12.7 Next SQPS Meeting

The next meeting of SQPS is scheduled to be held in Melbourne on 20 November 2009. Dr Pring will be able to attend

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 Deputy Chair, Ms Moira Munro, represents the PMHA on MHISS. Ms Munro reported on the following issues that were discussed at the most recent meeting of the MHISS, which was held in Melbourne on 10/11 September 2009.

13.1 Mental Health Interventions Classification Project (MHIC 09)

A draft MHIC 09 prototype was presented at the MHISS meeting for members' comments. This prototype incorporated the comments from the Expert Groups and members of a MHISS working group. A draft project plan for the further development and implementation was presented at the MHISS meeting. The project plan contained a history of the project as well as suggested project stages and a proposed timeline for pilot testing and implementation of the MHIC 09. MHISS members agreed to a proof of concept testing as the next stage and welcomed the offer by the ACT to act as the trial site. Copies of the latest version of the MHIC Project had been circulated to the PMHA. There is still some private sector concerns with the Intervention Classification for medication.

13.2 Fourth National Mental Health Plan 2009–14

MHISS is considering the implications of the Fourth National Mental Health Plan 2009-14 for the MHISS work plan. This will be further developed at the November 2009 MHISS meeting.

13.3 Report on discussion of the future arrangements of the Outcomes Expert Advisory Groups.

There was a lot of discussion at MHISS about these Expert Groups, which were established in 2004 to provide advice to the MHISS and to the Australian Mental Health Outcomes and Classification Network (AMHOCN) on the introduction and implementation of routine outcome measurement in mental health services, and on issues relevant to casemix classification. The Expert Groups were funded until June 2009. MHISS recently reviewed progress of the 42 mental health information priority initiatives, with a view to determining whether they were continuing priorities. As part of this review, MHISS considered the role and function of the Mental Health Outcomes Expert Groups and agreed on a new structure to facilitate the provision of expert clinical advice to MHISS and AMHOCN. The new structure will comprise a National Mental Health Information Development Expert Advisory Panel plus four specific panels (1) Adult, (2) Child and Adolescent, (3) Older Persons, and (4) Forensic. Terms of Reference for each of the panels were endorsed by MHISS and nominations for membership of the panels are currently being sought.

Ms Milthorpe reported that the sort of project Dr Pring had mentioned under Agenda Item 8.5 above had also been a recommendation arising from the work of the Expert Advisory Groups. They developed a proposal that they were going to take to the RANZCP, which Ms Milthorpe will forward to Dr Pring.

13.4 Next MHISS Meeting

The next Meeting of MHISS will be held in Melbourne on 19/20 November 2009 to coincide with the 20 November meeting of SQPS, which is also being held in Melbourne. Ms Munro will attend the meeting.

14. OTHER BUSINESS

There was no other business.

15. NEXT MEETING

It was agreed that the next face–to–face meeting of the PMHA would be held as follows.

10th PMHA Meeting
9:00 AM to 5:00 PM
Friday, 26 February 2010
The Adelaide Clinic
33 Park Terrace
Gilberton South Australia

16. CLOSE

There being no further business, the Chair closed the Meeting at 4:00 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	156,529	–1,452
Infrastructure	6,492	5,060	1,432
Recurrent and other expenses	23,412	17,858	5,554
Meetings of PMHA Face–to–Face	11,476	12,101	–625
Working Groups	2,912	9,111	–6,199
Other Meetings	7,028	2,147	4,881
Total before AMA Administration charge	206,397	202,807	3,590
AMA Administration Charge of 10%	20,640	20,640	0
Total	**227,037**	**223,447**	
Total PMHA Funds Remaining		***14,989***	

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 July 2007 to 30 June 2008	*53,473*		
New Hospital Enrollments and re–enrollments	*17,000*		
Total	**265,164**		
PMHA–CDMS EXPENDITURE	**Budget**	**Actual**	**Variance**
Staffing	138,326	134,694	3,632
Infrastructure	16,500	63,008	–46,508
Recurrent and other expenses	16,775	10,860	5,915
Attendance at PMHA and other stakeholder's meetings	5,391	2,079	3,312
Workshops	0	8,925	–8,925
Total before AMA Administration charge	176, 992	219,567	–42,575
AMA Administration Charge of 10%	17,699	17,699	0
Total	**194,692**	**237,266**	
Total CDMS Funds Remaining		***27,898***	

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	*–4,000*		
Total	**139,386**		
NETWORK EXPENDITURE	**Budget**	**Actual**	**Variance**
Staffing	73,951	80,266	–6,315
Meetings of the Network	37,039	31,877	5,161
Infrastructure for Network Chair	520	1,791	–1,271
Attendance of Network Representative at Other Meetings	8,225	6,879	1,346
Total before AMA Administration charge	119,735	120,813	–1,079
AMA Administration Charge of 10%	11,973	11,973	0
Total	**131,707**	**132,786**	
Total Network Funds Remaining		***6,600***	