PMHA | PRIVATE MENTAL HEALTH ALLIANCE

NEWSLETTER

17th Edition
June 2014

IN THIS ISSUE

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The PMHA is an alliance of major stakeholders who fund and provide mental health services in the Australian private sector. Originally established in 1996, the Alliance is committed to the provision of high quality mental health care in a private sector environment. PMHA addresses issues related to funding, classification, quality of care, outcome measurement, consumer and carer participation and related matters as they affect the private mental health sector.

The PMHA Newsletter provides a brief summary of some of the issues being progressed by our Private Mental Health Alliance, and it's Centralised Data Management Service (CDMS). As such it is intended to stimulate discussion and debate concerning the delivery of mental health services in the private sector. We welcome any feedback from our readers, which should be sent to: ptaylor@pmha.com.au

The PMHA Newsletter does not necessarily represent the views of participating organisations unless otherwise stated. Further information on the PMHA and its CDMS can be obtained from the PMHA Website at: www.pmha.com.au

The PMHA gratefully acknowledges the funding and support provided by the following organisations.

AMA
Australian Private Hospitals Association
Private Healthcare Australia
Australian Government Department of Health

From the Chair

Philip Plummer

Since our last Edition, the Commonwealth Commission of Audit has reported and the May Federal budget has been handed down. While the Federal Budget saw the Government stick with its pre–election committments to mental health, we still won't have the full picture until the *National Mental Health Commission's Review of Mental Health Programs and Services* is completed in November. In the interim, we have already met with the Commission and provided data from the PMHA's Centralised Data Management Service (CDMS) for the Review. We have also been busy with important work in several other areas.

PMHA's Patient Experiences of Care Measure

During the 2011–13 PMHA Quality Improvement Project (QIP), a *PMHA Patient Experiences of Care Measure* (PEx) for both overnight inpatient care and ambulatory care was developed. Implementation by our participating private psychiatric hospitals coincided with the release of the latest version of the CDMS *Hospitals Standardised Measures database* (HSMdb) software in late 2013. Hospitals were provided with the new PEx Survey templates, a detailed PEx Implementation Guide, and the updated HSMdb database application.

At the start of QIP, we weren't sure how the additional burden of an experience of care measure would be received when our participating hospitals were already collecting clinical outcomes measures (the HoNOS and MHQ14). However, in the very first quarter of data submitted (Oct–Dec 2013) we had 15 hospitals collecting the PEx survey. In addition, in just this first quarter of implementation, these hospitals have managed to collect 1,798 Surveys.

> THIS IS AN OUTSTANDING RESULT! WE SINCERELY CONGRATULATE AND THANK OUR PRIVATE HOSPITALS FOR PARTICIPATING IN WHAT IS YET ANOTHER MILESTONE FOR THE PRIVATE SECTOR.

The CDMS has now begun reporting PMHA–PEx statistics back to Hospitals within their Standard Quarterly Reports.

Our CDMS Director, Allen Morris–Yates, provides more details in this Edition.

PMHA Principles Webinar

Readers will recall, that we released our *Principles for Collaboration, Communication and Cooperation between Private Mental Health Service Providers*, at the end of last year. To assist in their promotion, the Mental Health Professionals Network (MHPN) dedicated its thirtieth webinar to the Principles. Held at 7.15 PM on 25 March, the webinar ran for 75 minutes and had an interdisciplinary focus on collaborating to optimise the support provided to a young woman (Cassie) as she utilised a range of mental health services. The webinar highlighted ways practitioners from different mental health disciplines can work effectively together to deliver an improved service. Panelists included:

1. *Ms Janne McMahon* (South Australian based consumer advocate)
2. *Dr Caroline Johnson* (Victorian based GP)
3. *Dr Louisa Hoey* (Victorian based clinical psychologist)
4. *Dr Bill Pring* (Victorian based psychiatrist)
5. *Dr Mary Emeleus* (Queensland based GP) will facilitated the panel discussion.

MHPN received 1,138 registrations and 433 of those logged in over the course of the live webinar. In March, there were a further 90 plays of the recording and another 80 in April bringing the tally to 603. MHPN anticipate this number will continue to grow into the future and the webinar is now part of the MHPN Webinar Library. You can view it at: http://www.mhpn.org.au/webinars

Guidelines for Determining Benefits for Health Insurance Purposes for Private Health Carer Report 2011–13

Having completed its work on the Principles, our Collaborative Care Models Working Group has now started to review the 2012 Edition of the *Guidelines for Determining Benefits for Health Insurance Purposes for Private Mental Health Care* (Guidelines). The Guidelines are primarily intended to provide guidance for hospitals and health insurers in determining health insurance benefits for private patient hospital–based mental health care. It is anticipated that the review will be completed by the end of this year.

Welcome Maitland Private

We warmly welcome Maitland Private Hospital in New South Wales and its 24 bed mental health. Maitland Private recently signed up to participate in the work of the PMHA, its CDMS and the Private Mental Health Consumer Carer Network.

Change in representation

Our longstanding representative for the Australian Medical Association, Dr Choong–Siew Yong, completed his term as the Craft Group Representative for Psychiatry on the Associations's Federal Council at the 13/14 May 2014 AMA National Conference. Professor Jeffrey Looi from Canberra has taken up that position and replaced Dr Yong on the PMHA. We welcome Jeff and thank Choong–Siew for his many years of committed support for our work in the private mental health sector.

Phil Plummer is the Independent Chair of the PMHA based in Adelaide

Activity Based Funding and Mental Health

Ms Moira Munro

As some of our readers may know, last year the Independent Hospital Pricing Authority (IHPA) tendered to engage a suitably qualified consultant (or consortium) to undertake a mental health costing and classification study and to develop the national Activity Based Funding (ABF) mental health classification system, which was scheduled for implementation by 1 July this year. The implementation date for the ***Australian Mental Health Classification*** was subsequently revised to **1 July 2016**, because of the complexities involved in the development of the classification for mental health.

Consultants

An open tender process for this project was conducted between October and November 2013, however no suitable responses were received and the process discontinued. The statement of requirement was refined to cover the costing aspect only and a limited tender process was conducted in December 2013. HealthConsult was the preferred tenderer. HealthConsult will be required to provide the draft final report and mental health costs dataset by March 2015, with the final report and the final study infrastructure due by April, 2015.

Project Management

IHPA will is responsible for overall management of the project. IHPA will be supported by a Mental Health Costing Steering Committee to oversee the design, compilation, and implementation of the costing study. I have been appointed by the Australian Private Hospitals Association (APHA) to represent the private sector on the Steering Committee with the PMHA's CDMS Director, Allen Morris–Yates, as my alternate. The Steering Committee will operate until 30 June 2015. It is anticipated that the costing study will involve at least 9 pilot sites, at least 3 of which will be private psychiatric hospitals. The National Mental Health Service Planning Framework is also going to be used.

The Mental Health Costing Steering Committee will work with IHPA and its Mental Health Working Group to:

- Assist in the development of the data request specification
- Refine the proposed costing methodology
- Refine the proposed framework for the ideal sample of participating hospitals
- Actively engage of hospitals and hospital staff for the duration of the project
- Assist in addressing issues as they arise
- Provide feedback on data samples and the final dataset
- Provide feedback on written reports as required.

Consultation

In May, IHPA released a consultation paper regarding the processes that are proposed to conduct the mental health costing study.


HealthConsult
Better thinking. Better advice.
Prepared for the Independent Hospital Pricing Authority
Mental Health Costing Study
Discussion Paper for Consultation
IHPA is calling for submissions on this Discussion Paper by the closing date of Friday, 30th May, 2014
HealthConsult Pty Ltd
27th April 2014

The consultation paper was prepared by a consortium led by the HealthConsult as a component of their work on the mental health costing study. The paper provided an overview of key issues for consideration and posed a series of focused consultation questions. Members of the public and all interested parties were invited to make submissions by 30 May 2014.

Moira is the Deputy Chair of the PMHA and CEO of Perth Clinic. Moira represents the APHA on both IHPA's Mental Health Working Group and its Mental Health Costing Steering Committee.

Improving National Healthcare Agreement performance Indicator #17: Treatment rates for mental illness

Allen Morris–Yates

The Australian Institute of Health and Welfare (AIHW) is seeking the assistance of the PMHA with improving the measurement of the *National Healthcare Agreement performance indicator #17: Treatment rates for mental illness* (formerly NHA indicator #21). At present, performance indicator #17 is calculated as the proportion of the Australian population receiving clinical mental health services, covering public, private, and Medicare (MBS)/Department of Veterans Affairs (DVA) subsidised services.

Community Mental Health Care (CMHC) client counts at the State/Territory level are used as the measure of those in receipt of public services, while patient counts from the PMHA's CDMS are used as the measure of those in receipt of private services. The indicator is calculated both nationally and by State/Territory and disaggregated, where possible, by 10–year age group, Indigenous status, residential remoteness and Socio–Economic Indexes for Areas (SEIFA) quintiles.

Project Proposal

Currently, the counts and calculations are produced separately for these datasets, although there is known to be overlap between them. The AIHW has been tasked to carry out data development work to attempt to measure and remove this known over count. This is the 2nd phase of the project, begun in 2010. The 1st phase linked 2009–10 Medicare data with CMHC data for three jurisdictions and found that the combined count would be reduced by around 5% taking into account this overlap.

The 2nd phase will pilot test the feasibility of incorporating DVA and PMHA CDMS data into the linkage along with MBS and CMHC data. It is proposed that this pilot testing be carried out with 2010–11 data.

Ethical approval for this extension of the project has been granted by the Ethics Committees of both the AIHW and the Australian Government's Department of Health.

Data Protocols

AIHW has well developed protocols for data linkage and simultaneous protection of the privacy of individuals. Apart from an established Ethics Committee and project–specific staff confidentiality undertakings, the AIHW has a dedicated Data Linkage Unit, which now has accreditation as a Commonwealth Data Integration Authority. This unit works only with the identifying data items to be used for linkage (see below) to produce a linkage key which is then passed to the subject area (in this case the Mental Health & Palliative Care Unit) to be combined with the other analytical data items in analysis files which **do not include the identifying data items**.

Data Required

To undertake this work AIHW requires a list of PMHA–CDMS clients in receipt of mental health–related services in 2011–12 with the following data fields:

- Statistical Linkage Key 581 (specified below) or in the case of PMHA a hashed version (encrypted version) of the SLK.
- Postcode of client at all hospitalisations in 2010–11 (if different)

The statistical linkage key (SLK581) combines a coded name with date of birth and sex as shown below:

Figure 1– Statistical Linkage Key 581

The components of the SLK581 are:

– second, third and fifth letters of the client's last name
– second and third letters of the client's given name
– date of birth (8 digits)
– sex of the client (1–male, 2–female).

*For example, F**RA**NK G**ALLA**GHER, male, born 26th Jan 1960, would have an SLK of: ALARA260119601*

Postcode is also required as it can be used to clarify or check links in the situation where (hashed) SLK581 matching produces ambiguous matches. The residential remoteness and SEIFA disaggregations of the indicator can also be derived from postcode.

The potential benefits of this data linkage project are substantial in terms of more targeted planning and better integration of mental health care , the risks to people's privacy are minimal. The personal data will only be used to calculate the indicator to be published in aggregate form, with broad level socio–demographic breakdowns.

The PMHA has supported the AIHW request and agreed that participation in this important project should be supported. However, before PMHA's CDMS is able to supply the requested data, the PMHA felt it important to have the support of private sector consumers and carers for this work. The AIHW request was, therefore, referred to the National Committee of the Private Mental Health Consumer Carer Network, who after careful consideration have endorsed the Project Proposal – on the proviso that date of birth is not provided.

Allen is the Director of the PMHA's CDMS based in Adelaide

Transcranial Magnetic Stimulation

Update of the TMS Service at The Adelaide Clinic

Carol Turnbull

Repetitive Transcranial Magnetic Stimulation (rTMS) produces longer lasting effects and is a non invasive way of stimulating nerve cells in superficial areas of the brain. It is a relatively new treatment for depression and relies on direct stimulation of the brain using a magnetic pulse to generate brief electrical currents to stimulate nerve cells in the regions of the brain involved in depression. Unlike more invasive treatments for medication resistant depression such as Electroconvulsive Therapy (ECT), rTMS requires no anaesthetic and there is no associated cognitive impairment.

During an rTMS procedure, an electrical current passes through a wire coil placed over the scalp. The current induces a magnetic field that allows an electrical current to pass through to the brain (2cm). This produces a depolarization of nerve cells resulting in the stimulation of brain activity. It can be applied as a single stimulus or repeated many times per second, with variation in intensity, site and orientation of the magnetic field.

rTMS at The Adelaide Clinic

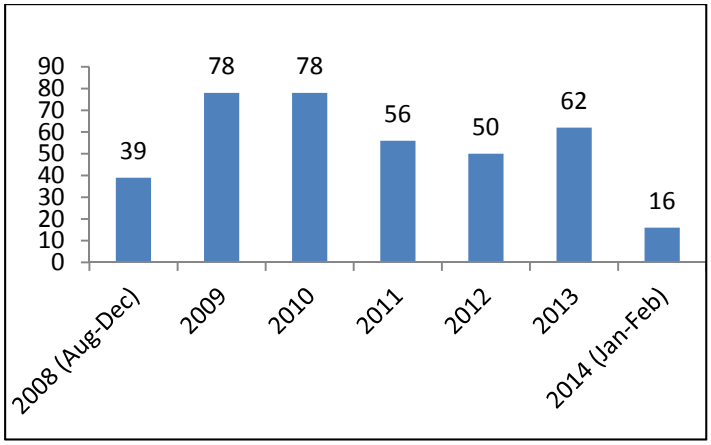
The rTMS treatment service established at The Adelaide Clinic commenced in 2008 under research protocols and continues in that vein. As part of the organisation's commitment to ongoing research and evaluation of rTMS, our researchers initially designed a study to evaluate the optimal spacing of treatments, and treatment course length. There is evidence that rTMS administered five days/week and rTMS administered three days/week are both effective.

Inclusion Criteria

Inclusion criteria for patients suitable for our TMS service are:

- Current major depressive episode
- Over 18 years of age
- No history of seizures or epilepsy
- No metal in the head eg surgical clips
- No psychoses
- Willing and able to attend 3–5 mornings per week for an hour at a time, for up to 6 weeks.

Patients stay under the care of their usual psychiatrist whilst having rTMS treatment. 86.4% (152) were taking antidepressant medication when assessed and remained on that medication during treatment.



Total referrals = 379

Since we began at The Adelaide Clinic, 239 patients have begun treatment courses.

193 first time courses, 46 repeat courses.

All of our patients met criteria for major depression:

Criteria	Mean	Standard Deviation	Range
Years since first episode of depression	19.7	13.5	1 to 5
Number of Episodes	7.6	7.8	Up to 40
Duration of current episode	19.8mths	44.2mths	Up to 25yrs

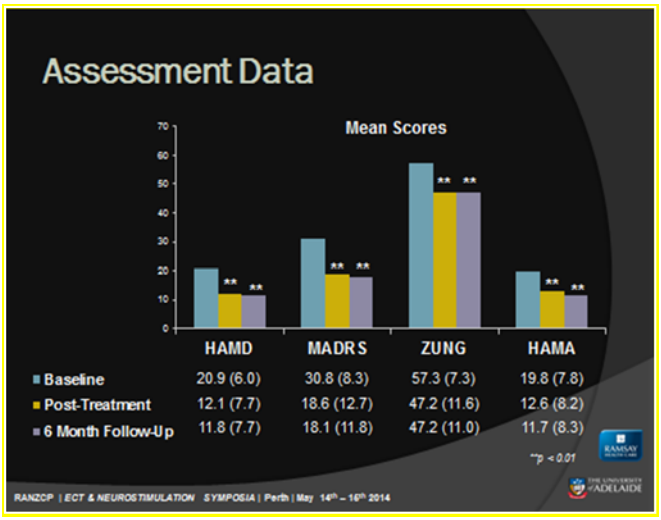
Transcranial Magnetic Stimulation

Update of the TMS Service at The Adelaide Clinic

Carol Turnbull

When we look at 5 year data (2009 – 2013), 176 patients have completed treatment. 137 of those were first courses with 35 second courses and four third courses. Ages ranged from 17 through to 82 years of age. 102 were females (58%) – one was pregnant. 70.5% (124 patients) had trialled at least 5 antidepressants. 50% (90 patients) had received ECT previously. Each patient was assessed at the beginning and end of their treatment with:

- Hamilton Rating Scale for Depression;
- Montgomery–Asberg Depression Rating Scale;
- Zung self rating depression scale; and
- Hamilton Anxiety Rating Scale (HAMA: Hamilton 1959)



Slide reproduced courtesy of Professor Cherrie Galletly.

The results for all courses showed:

- 12.2% response rate
- 21.5% partial response
- 31.5% remission
- 32% no response.

Since 2008 we have studied:

- Bilateral vs Unilateral rTMS
- 3 days per week vs 5 days per week
- Enhanced rTMS (treatment combined with multiple psychological therapies)
- Treatment combined with Meditation or relaxation
- Maintenance rTMS
- TMS and Cognition.

Our results have shown an excellent safety record with no serious adverse events.

Maintenance TMS

We have treated a total of 20 patients with Maintenance TMS . Patients have received rTMS treatment every one, two or three weeks. Based on an analysis of the current 11 patients receiving maintenance rTMS the average number of days between treatments is 13.5 (SD=6.5) and the average number of treatments as part of their maintenance course is 70.2 (SD=45.55)

Funding Approvals

Since we started this project, the TMS machine has been granted Therapeutics Goods Administration (TGA) approval and at least one private health insurance fund has approved it as a treatment.

History

Interest in rTMS at The Adelaide Clinic began around 2006 and an rTMS clinical service for the treatment of depression was established in 2008. It was set up under Research protocols being funded by Ramsay Health Care SA Mental Health Services and our first patient was treated on the 4 August 2008.

Since then, 239 patients have begun treatment courses. Referral is by Psychiatrists credentialed to Ramsay Health Care. Patients are assessed by rTMS psychiatrist prior to acceptance for treatment. Once accepted, patients are "mapped" by the TMS Psychiatrist to determine the site of the DLPFC (Dorso Lateral Pre Frontal Cortex) by reference to the motor cortex and the intensity of stimulation required. Patients are then assessed by our Research Officer. The treatment program is currently 3 treatments per week for 6 weeks administered by hospital clinical staff. We use a Mag Pro R30 TMS machine. The follow up assessment is conducted by our Research Officer and finally a report is sent to the referring Psychiatrist.

The Future

Going forward, our Ramsay Health Care SA team in collaboration with the Royal Australian and New Zealand College of Psychiatrists are in the process of applying for a Medicare Benefits Schedule Item number. We are more than half way through this process.

Carol is the Chief Executive Officer for Ramsay Health Care in South Australia and represents the APHA on the PMHA.

PMHA's Centralised Data Management Service

Allen Morris–Yates

The PMHA's CDMS is the core business of the PMHA. It was established to support the implementation of a *National Model for the Collection and Analysis of a Minimum Data Set with Outcome Measures for Private Hospital–based Psychiatric Services*. The National Model has been implemented in all private facilities with psychiatric beds (Hospitals) across Australia and currently 100% participate in the services provided by the CDMS

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

Queensland

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

New South Wales

13. Albury Wodonga Private Hospital
14. Brisbane Waters Private Hospital
15. Baringa Private Hospital
16. Campbelltown Private Hospital
17. Dudley Private Hospital
18. Hills Private Hospital
19. Maitland Private Hospital
20. Mayo Private Hospital
21. Mosman Private Hospital
22. Northside Clinic
23. Northside Cremorne Clinic
24. Northside West Clinic
25. Northside Macarthur Clinic
26. St John of God Hospital Burwood
27. St John of God Hospital Richmond
28. South Coast Private
29. South Pacific Private
30. St Vincent's Private Hospital
31. Sydney Clinic
32. Sydney South West Private Hospital
33. Toronto Private Hospital
34. Warners Bay Private Hospital
35. Wesley Private Hospital Ashfield
36. Wesley Private Hospital Kogarah

Australian Capital Territory

37. Calvary Private Hospital

Victoria

38. Albert Road Clinic
39. Beleura Private Hospital
40. Delmont Private Hospital
41. Epworth Camberwell
42. Essendon Private Hospital
43. Geelong Clinic
44. Melbourne Clinic
45. Malvern Private Hospital
46. Mitcham Private Hospital
47. Northpark Private Hospital
48. St John of God Hospital Warrnambool
49. St John of God Pinelodge Clinic
50. Victoria Clinic
51. Wyndham Clinic

South Australia

52. The Adelaide Clinic *
53. Fullarton Private Hospital
54. Kahlyn Day Centre

Western Australia

55. Abbotsford Private Hospital
56. Hollywood Private Hospital
57. The Marian Centre
58. Perth Clinic

Tasmania

59. The Hobart Clinic
60. St Helens Private Hospital
61. North West Private
62. Calvary Clinic

* Licensed to take involuntary admissions

PMHA's Centralised Data Management Service (Continued)

Allen Morris–Yates

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

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

The two measures of clinical status are:

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

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

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

PMHA Patient Experiences of Care Measure

In addition, under the auspice of the 2011–13 PMHA Quality Improvement Project (QIP), a *PMHA Patient Experiences of Care Measure* **(PEx)** for both overnight inpatient care and ambulatory care was developed. The PEx Survey instrument together with PMHA–PEx related local analysis and reporting functionality were then integrated within the CDMS HSMdb software. Implementation by Hospitals coincided with the release of the latest version of the HSMdb in the second half of 2013. In September 2013, Hospitals were provided with the new PEx Survey templates, a detailed PEx Implementation Guide, and the updated HSMdb database application.

In the very first quarter of data submitted (Oct–Dec 2013) we have had 15 Hospitals collecting the PMHA–PEx survey. In addition, in just this first quarter of implementation, these Hospitals have managed to collect 1,798 Surveys. This is an outstanding achievement that Hospitals should be very proud of. We would also like to thank the Australian Private Hospitals Association Psychiatric Committee and Lucy Cheetham at the APHA for all the effort they have put in to getting the information out to hospitals and for the encouragement that they have provided.

The CDMS has begun to report the PEx statistics back to Hospitals within their Standard Quarterly Reports.

For those hospitals who have not yet started collecting and need any further information or help, please don't hesitate to contact myself, or your hospital representatives on the PMHA, Moira Munro and Carol Turnbull.

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Internet Access to the PMHA's CDMS

At the beginning of the QIP, the Commonwealth provided additional funding, which enabled the architecture to be put in place for secure internet access for our participating Hospitals and private health insurers to the data held by the CDMS. The PMHA has commissioned Debra Tippet from Minter Ellison to prepare a contract to enable access to the CDMS. Debra is a specialist IT contracts lawyer. Both the finalisation of the Agreement and testing of internet-based access for Hospitals and private health insurers should now be completed before the end of the next financial year 2014–15.

Allen is the Director of the PMHA's CDMS

Stakeholder Round Up

Australian Medical Association (AMA)

Since the last edition, the AMA made a submission to the National Mental Health Commission's *Review of Mental Health Programs and Services*. The AMA believes that it is of great importance to ensure that appropriate services are available to support the mental health of all Australians. The submission covered the following areas.

- Gaps remaining in the transition from institutional to community–based care
- Sustained support for Acute Care settings
- Improved mental health support for medical professionals and the emerging generation of doctors
- Addressing mental health needs in rural and remote areas
- Guaranteeing the mental health and social and emotional well–being of Aboriginal and Torres Strait Islander peoples
- Provision of adequate mental health care in the criminal justice system
- The mental health of asylum seekers in detention.

The AMA also made a submission to IHPA on the consultation paper regarding the processes that are proposed to conduct the ABF Mental Health Costing Study. The AMA submission supported the inclusion of consultation-liaison services in the Costing Study, as an essential component of the modern medical care provided by psychiatrists.

Australian Private Hospitals Association (APHA)

Talking Up Mental Health In Private Hospitals

In the quarter October–December 2013, 15 hospitals participated in the first quarter of implementation for the collecting the PMHA–CDMS Patient Experience of Care Survey collecting 1789 surveys. So far the feedback from these hospitals has been extremely positive and those who have received their data reports have found the information provided useful in guiding further service enhancement. An article from the Perth Clinic will be featured in the Winter edition of Private Hospital magazine on their experience with the Patient Experiences of Care implementation in their hospital.

The APHA was pleased recently to have the opportunity to make a submission to the National Mental Health Review and this submission can be accessed on line. The submission is illustrated with 28 stories about the diversity of ways private psychiatric hospitals are striving to meet the needs of people living with a mental illness.

In May, APHA members around Australia celebrated Private Hospitals Week and lit up social media on Australia's Private Hospital's Facebook page, Google+ page @Priv8hospitals Twitter account and YouTube account. During Private Hospitals Week 564,000 people were reached online and 14,170 have watched the Private Hospitals Video with many others creating a lively discussion on why people choose private hospitals when they most need it.

APHA and its members continue to strive to get the message out there about the services being delivered to the over 32,000 people who each year turn to private psychiatric hospitals. APHA looks forward to meeting you online in this dynamic conversation. Stay tuned too for our Mental Health Week campaign in October 2014.

Private Healthcare Australia (PHA)

The Private Health Insurance sector continues to support private mental health services in Australia, paying substantial benefits for the care of our valued members in both the private and public hospital settings. In the 2008-2009 financial year, benefits totalling $246,651,893 were paid in total, of which $3,699,940 were paid for private patients in the public sector. By the end of the 2012-2013 financial year, this had increased to a total of $442,449,620 with $14,892,183 of that amount in the public sector. For the five year period 2008 – 2013, a total of $1,725,212,441 has been paid for the treatment of mental health patients, including a total of $48,830,217 that has been paid to the public sector.

Given the rising demand for mental health services in the Australian community, it remains a challenging priority for health funds to continue to make wise purchasing decisions for these services whilst ensuring the private health insurance product remains affordable for hard-working Australians.

The importance of quality improvement, evidence-based outcomes and the provision of the best care in the best setting and in the appropriate time frame remains critical. Wherever possible, Private Healthcare Australia and health insurance representatives participate in collaborative industry initiatives aimed at improving and prioritising access, measurement and evaluation of the best services available for our Members.

The benefits gained from key stakeholders across industry working together with the unanimous objective of looking after consumer and carers of Australian mental health services cannot be understated and remains a priority for the private health insurance sector.

Stakeholder Round Up

Private Mental Health Consumer Carer Network (Network)

Despite several calls for nomination, the Network Coordinator positions for New South Wales and Tasmania remain vacant. Until such time as Coordinators for these States can be appointed the Network Chair, Janne McMahon, has given a firm commitment to ensure that the voice of Network Members in these States are heard.

This year Janne has already convened two Network Forums in New South Wales and one in Tasmania. The Forums have been well attended highly productive events and have helped inform the work of the Network's National Committee.

Beyond that, the Network has made a submission to the National Mental Health Commission's Review of Mental Health Programs and Services and is continuing to pursue funding for a proposed carer project directed at the development of a practical guide for working with carers of people with a mental illness.

The Network website is at www.pmhccn.com.au

Australian Government Department of Veterans' Affairs (DVA)

Subject to the passage of legislation through Parliament, a number of new mental health initiatives will be introduced from 1 July 2014, to strengthen access to DVA's mental health service system. These initiatives will provide:

- greater access to the Veterans and Veterans Families Counselling Service (VVCS) for ex–serving members and their families. Newly eligible groups would include people with border protection service, service in a disaster zone either in Australia or overseas, service as a submariner, personnel involved in training accidents and members medically discharged. Access to VVCS counselling services will also be extended to their partners and dependant children;
- greater access to existing arrangements whereby DVA will pay for mental health treatment for eligible veterans and peacetime members without the need to establish that their mental health condition is related to service. Currently, these arrangements cover diagnosed post traumatic stress disorder, anxiety, and depression. From 1 July 2014, DVA would also pay for treatment for diagnosed alcohol and substance use disorders, and an increased number of individuals with peacetime service will also become eligible; and
- a new physical and mental health assessment for ex–serving personnel from their GP, to be funded under Medicare. The assessment will help GPs diagnose and identify early any mental and physical health concerns and to treat or refer appropriately to other services.

Case Formulation Training Online

Many veterans suffer from more than one mental health issue, such as posttraumatic stress disorder (PTSD), depression, anxiety, or alcohol abuse, and to help providers make better sense of complexity, the Department of Veterans' Affairs has released a new free online training program on the Case Formulation Approach.

The Case Formulation online program assists providers to identify and focus on the presenting problems that are likely to have the most impact on recovery and help set priorities for treatment. Developed by the Australian Centre for Posttraumatic Mental Health, the program explains the case formulation approach, and gives practitioners the opportunity to hear from experts, watch demonstrations of case formulation, and then practice case formulation based on veteran case studies.

The program offers mental health professionals skills in:

- Using a simple and practical model that considers presenting, predisposing, precipitating, prognostic and perpetuating factors;
- Organising information gathered during assessment and identifying any further need for assessment
- Developing hypotheses about factors that impact on a client's distress and mental and physical health problems on a day–to–day basis, and using these to inform treatment planning;
- Using a functional analysis technique to assist with assessment, case formulation and treatment planning; selecting treatment targets and evidence–based interventions and sequencing interventions for complex cases; and
- Working collaboratively with clients on case formulation and treatment planning.

Case Formulation is free, interactive and engaging, and provides easy to use practical tools to assist with learning and adoption of case formulation, and additional resources to help their work with veterans. For further information on Case Formulation and other veteran mental health related education programs, please go to www.at–ease.dva.gov.au/professionals/professional–development

Fact Sheet

The private sector plays an essential role in the overall provision of mental health services in Australia. Data from the PMHA's Centralised Data Management Service (PMHA–CDMS) Annual Statistical Report shows that for the 2012–13 Financial Year, there were 30 stand–alone private psychiatric hospitals and 26 psychiatric units located within private general hospitals in operation in Australia. Together these Hospitals had approximately 2,339 psychiatric beds. The hospitals that participated in the PMHA's CDMS during that financial year accounted for approximately 97% of all private psychiatric beds.

During the financial year the 54 private Hospitals participating in the CDMS admitted 31,846 patients for psychiatric care. Of those patients, 24,406 had a total of 36,126 separations from overnight inpatient care (excluding brief overnight admissions for sameday procedures) with an average length of stay of 19 days. The demographic and diagnostic profiles of those patients are shown below in Figures A and B. For the 17,169 patients who received any care on a Sameday or Outreach basis (referred to under the National Model as Ambulatory care) the average number of Days of care per patient was 13. Of those patients seen in the Ambulatory Care service setting, 9,000 also had at least one overnight inpatient admission.[1]

Figure C in the column opposite provides a comparison of patients MHQ–14 summary scores at Admission and Discharge with scores on the measure derived from the Australian Bureau of Statistics' National Health Survey conducted in 1995. As can be seen, Patients reported mental health, social and role functioning at Admission are very much worse than that of the general population. By discharge they have improved greatly, but are still not as well on average as the general population.

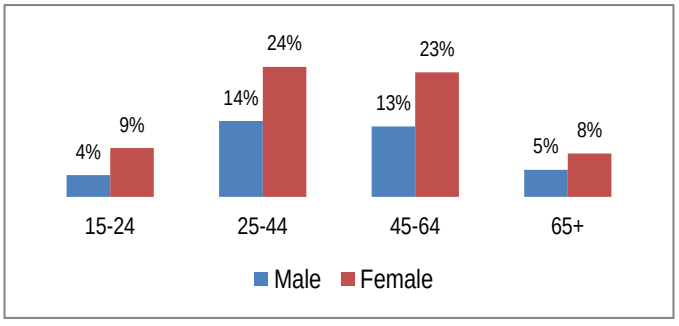

Figure A: Demographic profile (Age group by Sex) of patients admitted to participating private hospitals

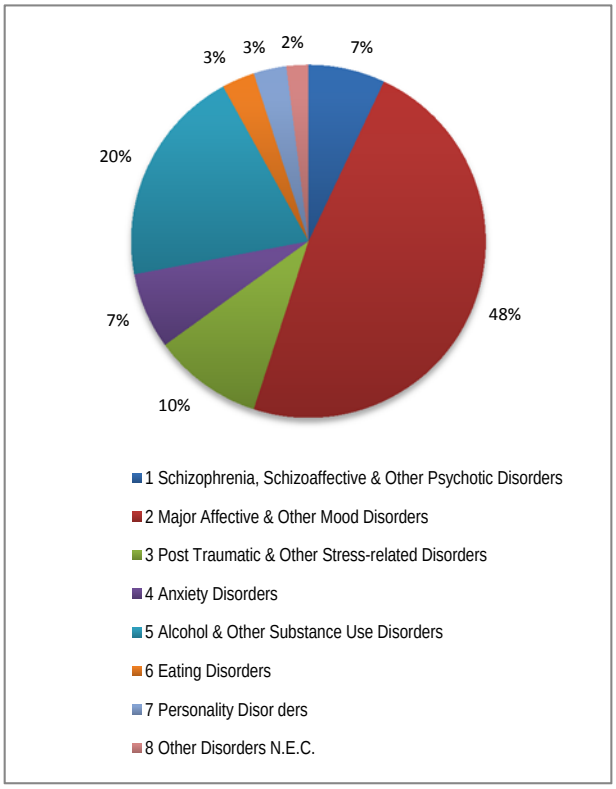

Figure B: Diagnostic profile (proportion in each of the eight major MHDGs) for Episodes of Overnight Inpatient Care during the Financial Year

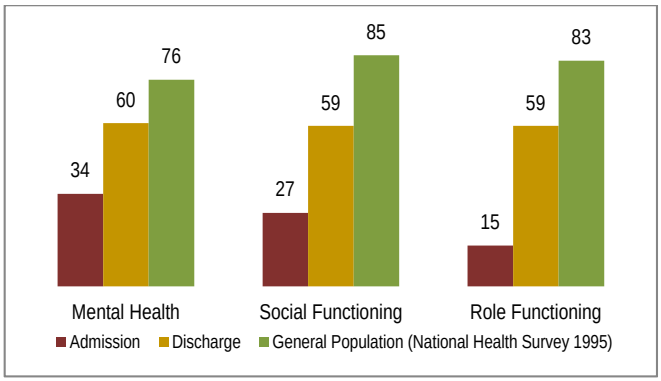

Figure C: Comparison of patients' self–reported clinical status at admission and Discharge with that of the General Population.

Reference

[1] *PMHA–CDMS Private Hospital–based Psychiatric Services 1 July 2012 to 30 June 2013: Annual Statistical Report from the PMHA's Centralised Data Management Service regarding the services provided by participating Private Hospitals with Psychiatric Beds and Private Psychiatric Day Hospitals Annual Statistical Report for 2012–13*, March 2014.

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