PMHA | PRIVATE MENTAL HEALTH ALLIANCE

NEWSLETTER

18th Edition
December 2014

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Wishing all our readers a very merry Christmas and a happy and safe New Year

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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

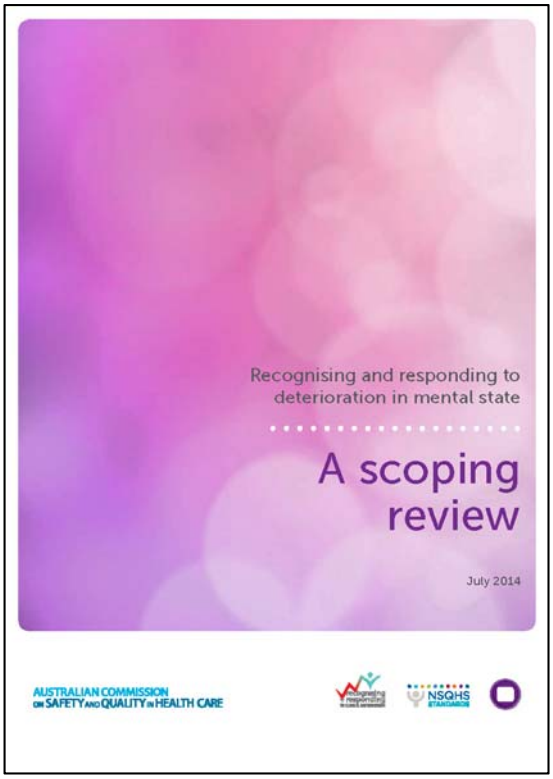
From the Chair

Philip Plummer

Welcome to the Christmas Edition of our newsletter, as yet another busy and productive year draws to a close. Since our last edition, the substantive work involved in drafting and negotiating our next funding agreement, known as the *AMA Agreement for Services 2015–18*, has begun. We are aiming for this next Agreement to support the activities of the PMHA, our Centralised Data Management Services (CDMS), and the Private Mental Health Consumer Carer Network (the Network or PMHCCN) for the next three financial years from 1 July 2015 to 30 June 2018. The Agreement along with its supporting budgets and work plans are in the pipeline and we anticipate the final stakeholder approval processes will be completed by the end of May next year.

Recognising and Responding to Deterioration in Mental State: A Scoping Review

Earlier this year, the Australian Commission on Safety and Quality in Health Care commenced work focused on recognising and responding to deterioration in mental state. Readers will recall that, last year, the Commission engaged Craze Lateral Solutions to prepare a review of policy and practice relating to recognising and responding to deterioration in mental state. Its purpose was to explore the current knowledge base and practices for recognising and responding to deterioration in mental state in acute care settings, and to determine whether and how the Commission could contribute to addressing any identified gaps.



The process involved a review of the literature and a series of focus groups and interviews with consumers, carers, healthcare professionals, managers and executives. Craze Lateral Solutions worked with Dr Peter McGeorge, Mr Douglas Holmes and Mr Steven Bernardi, Mental and Homeless Health Services, O'Brien Centre for Urban Health, St Vincent's and Mater Health Services, Ms Eileen McDonald, Carers NSW, and the **PMHA** in completing the review for the Commission.

The Commission is now expanding its existing Recognising and Responding to Clinical Deterioration Program to encompass deterioration in mental state, and the findings of this review will inform the development of this work to improve the safety and quality of care for consumers with a mental health condition.

Copies of the scoping review are available from the Commission's website, www.safetyandquality.gov.au

National Mental Health Commission Review 2014

While that work was going on, we also provided statistics for the National Mental Health Commission as part of its Review of Mental Health Programmes and Services. In this Edition, our CDMS Director, Allen Morris–Yates, talks about the review and highlights some of the CDMS statistics provided for the Commission.

Activity Based Funding and Mental Health

Since our last Edition, I wrote to the CEO of the Independent Hospitals Pricing Authority (IHPA), Tony Sherbon, outlining the PMHA's request for IHPA to provide funding to enable our CDMS to support private hospitals' participation in the Mental Health Costing Study. IHPA agreed and the CDMS has been working with the four private hospitals' participating in the Study. Our Deputy Chair, Moira Munro, provides further detail in this Edition on this important work.

Key Performance Indicators (KPIs)

In October, we sent all our participating private hospitals a copy of the KPIs for Australian Public Mental Health Services, which were developed to improve accountability and transparency at the Mental Health Service Organisation (MHSO) level. The 15 indicators aim to address the Health System Performance tier of the National Health Performance Framework by monitoring performance within public MHSO. It is anticipated that future indicator work will incorporate private and non–government MHSO activity to provide a complete measure of national service performance. The ultimate goal of the MHS KPIs is that consumer outcomes are improved as a result of improved quality of service.

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

National Mental Health Commission Review of Mental Health Services and Programmes

Allen Morris–Yates

As our readers will know, in 2014 the Australian Government asked the National Mental Health Commission to conduct a national Review of Mental Health Services and Programmes.

Over the course of this year, the review has been examining existing mental health services and programmes across the government, private and non–government sectors. The focus of the review is to assess the efficiency and effectiveness of programmes and services in supporting individuals experiencing mental ill health and their families and other support people to lead a contributing life and to engage productively in the community. Programmes and services may include those that have as a main objective:

- the prevention, early detection and treatment of mental illness;
- the prevention of suicide;
- mental health research, workforce development and training; and/or
- the reduction of the burden of disease caused by mental illness.

The review is considering the following.

- The efficacy and cost–effectiveness of programmes, services and treatments.
- Duplication in current services and programmes.
- The role of factors relevant to the experience of a contributing life such as employment, accommodation and social connectedness (without evaluating programmes except where they have mental health as their principal focus).
- The appropriateness, effectiveness and efficiency of existing reporting requirements and regulation of programmes and services.
- Funding priorities in mental health and gaps in services and programmes, in the context of the current fiscal circumstances facing governments.
- Existing and alternative approaches to supporting and funding mental health care.
- Mental health research, workforce development and training.
- Specific challenges for regional, rural and remote Australia.
- Specific challenges for Aboriginal and Torres Strait Islander people.
- Transparency and accountability for outcomes of investment.

The Commission is scheduled to report to the Federal Government at the end of November on the results of its Review.

In May this year, we met with the Commission's CEO, David Butt, to discuss the Review and the role that the PMHA and its CDMS play in the private sector. The Commission subsequently made a formal request for the CDMS to provide the following statistics for the Review.

Table 1: Total charges (AUD) against Health insurance funds, by patients' Area of usual residence (Jurisdiction and Locality), 2012–13.

	State or territory				
Locality	NSW & ACT	Vic	Qld	WA, SA, NT & Tas	Australia
Urban	119,658,502	103,969,530	71,544,619	53,722,144	348,894,795
Non–urban	20,902,396	14,096,763	17,513,684	20,684,107	73,196,950
Total	140,560,898	118,066,293	89,058,303	74,406,251	422,091,745

Note: Total charges against all Payment sources during 2012–13 was $476,306,571.

Table 2: Number of patients by Payment source and patients' Area of usual residence (Jurisdiction and Locality), 2012–13.

	State or territory				
Payment source	NSW & ACT	Vic	Qld	WA, SA, NT & Tas	Australia
Health insurance fund	9,331	7,552	5,600	5,824	28,307
Other payers	1,299	643	1,039	566	3,547
Self–funded	88	27	27	30	172
Total	10,718	8,221	6,666	6,420	32,025

National Mental Health Commission Review of Mental Health Services and Programmes

(Continued)

Allen Morris–Yates

Table 3: Number of patients by care provided, by patients' Area of usual residence (Jurisdiction and Locality), 2012–13.

		State or territory				
Care type	Locality	NSW & ACT	Vic	Qld	WA, SA, NT & Tas	Australia
Overnight inpatient	Urban	7,313	5,321	4,048	2,876	19,558
	Non–urban	1,514	855	1,311	1,301	4,981
	Total	8,827	6,176	5,359	4,177	24,539
Ambulatory	Urban	4,035	4,136	2,658	2,967	13,796
	Non–urban	517	334	434	605	1,890
	Total	4,552	4,470	3,092	3,572	15,686
All care types	Urban	8,985	7,237	5,154	4,816	26,192
	Non–urban	1,733	984	1,512	1,604	5,833
	Total	10,718	8,221	6,666	6,420	32,025

Table 4: Number of patient episodes by care provided and number of care days, by patients' Area of usual residence (Jurisdiction and Locality), 2012–13.

			State or territory				
Care type		Locality	NSW & ACT	Vic	Qld	WA, SA, NT & Tas	Australia
Overnight inpatient	Number of patient episodes	Urban	10,093	7,929	6,687	4,264	28,973
		Non–urban	2,023	1,261	1,943	1,926	7,153
		Total	12,116	9,190	8,630	6,190	36,126
	Number of care days	Urban	210,080	152,900	135,634	80,513	579,127
		Non–urban	44,012	24,496	37,855	35,359	141,722
		Total	254,092	177,396	173,489	115,872	720,849
	Average care days	Urban	28.7	28.7	33.5	28.0	29.6
		Non–urban	29.1	28.7	28.9	27.2	28.5
		Total	28.8	28.7	32.4	27.7	29.4
Ambulatory	Number of patient episodes	Urban	4,672	3,927	2,868	3,174	14,641
		Non–urban	373	312	363	438	1,486
		Total	5,045	4,239	3,231	3,612	16,127
	Number of care days	Urban	48,667	63,081	39,952	31,349	183,049
		Non–urban	4,893	3589	4,383	6,908	19,773
		Total	53,560	66,670	44,335	38,257	202,822
	Average care days	Urban	12.1	15.3	15.0	10.6	13.3
		Non–urban	9.5	10.7	10.1	11.4	10.5
		Total	11.8	14.9	14.3	10.7	12.9

Table 5: Overnight inpatients, Mode of separation by patients' Area of usual residence (Jurisdiction and Locality), Australia, 2012–13

		State or territory				
Mode of separation	Locality	NSW & ACT	Vic	Qld	WA, SA, NT & Tas	Australia
Discharge/transfer to an(other) acute hospital	Urban	161	238	164	82	645
	Non–urban	45	20	44	33	142
	Total	206	258	208	115	787
Discharge/transfer to an(other) psychiatric hospital	Urban					21
	Non–urban					5
	Total					26
Discharge/transfer to a Residential Aged Care service, unless this is the usual place of residence	Urban					79
	Non–urban					12
	Total	57	22	6	6	91
Discharge/transfer to other health care accommodation (includes mother craft hospitals)	Urban					11
	Non–urban					6
	Total					17
Statistical discharge / type change	Urban					98
	Non–urban					28
	Total	43	19	18	46	126
Left against medical advice / discharge at own risk	Urban	312	155	103	30	600
	Non–urban	25	17	34	11	87
	Total	337	172	137	41	687
Statistical discharge from leave	Urban					52
	Non–urban					6
	Total			44		58
Died	Urban					12
	Non–urban					7
	Total					19
Other (includes discharge to usual residence / own accommodation etc.)	Urban	8,926	7,315	6,098	3,836	26,175
	Non–urban	1,911	1,216	1,833	1,857	6,817
	Total	10,837	8,531	7,931	5,693	32,992
Unknown / not supplied	Urban					1,280
	Non–urban					43
	Total	617	173	271	262	1,323
Total	Urban	10,093	7,929	6,687	4,264	28,973
	Non–urban	2,023	1,261	1,943	1,926	7,153
	Total	12,116	9,190	8,630	6,190	36,126

Note: Blank cells indicate the actual value has been supressed due to insufficient cases in that cell or in adjacent cells; insufficient cases being defined as less than five.

The PMHA is currently discussing which of these statistics might now be usefully included and routinely reported on in the CDMS Standard Quarterly Reports (SQRs).

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

Activity Based Funding and Mental Health

Moira Munro

In December 2012, the Independent Hospital Pricing Authority (IHPA) decided that a new mental health classification would be developed for mental health services in Australia for the purposes of activity based funding (ABF).

IHPA recognised that the Australian Refined Diagnosis Related Groups (AR–DRGs) was not the ideal classification in the longer term for mental health services, primarily because diagnosis is not as strong a driver of resource utilisation for mental health services, as it is in other acute services.

The development of the Australian Mental Health Care Classification (AMHCC) was foreshadowed in successive Pricing Frameworks and Three Year Data Plans, as well as through the IHPA Jurisdictional Advisory Committee and IHPA's Mental Health Working Group (MHWG).

At the Standing Council on Health meeting in April 2014, IHPA re–affirmed its commitment to develop the AMHCC Version 1.0 for implementation trials in 2015–16.

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

Readers will recall, that the following work has been undertaken to date.

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

The next phase of work is the development of the classification by 30 June 2015 for implementation trials in 2015–16 and commencement of pricing on 1 July 2016.

IHPA has developed a high level project plan, which outlines the work that will be undertaken to develop the AMHCC. The Plan and links to the National Mental Health Costing Study website are available on the IHPA website at: http://www.ihpa.gov.au/internet/ihpa/publishing.nsf/Content/mental–health

Essentially, there are three stages to the project.

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

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

PMHA's CDMS

Since our last Edition, IHPA has provided funding to enable the PMHA's CDMS Director, Allen Morris–Yates, to support the following four private hospitals' participation in IHPA's Mental Health Costing Study.

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

Allen developed a detailed analysis of the additional data collection requirements for these private hospitals in order to meet the Mental Health Costing Study Data Request Specification. The CDMS HSMdb software was modified to enable the collection of all components of the Mental Health Costing Study Data Request Specification.

Moira is the Deputy Chair of the PMHA and represents the APHA on IHPA's Mental Health Working Group

Veteran Mental Health Consultation Companion

Matthew Jackson

New technology is enabling accurate assessment and monitoring of mental health issues experienced by veterans, with the release of a new tablet app for Australian health practitioners. Earlier this year, the Department of Veterans' Affairs (DVA) released the Veteran Mental Health Consultation Companion (VHMC^2), an application for tablet devices which offers interactive assessment and treatment planning to assist mental health practitioners treating Australian veterans and serving members.

VHMC^2 is designed around a typical first consultation, offering:

- Mental Status Examination and Risk Assessment checklist.
- Client interface for psychometric and assessment measures, including K10, DASS–21, PSWQ, FQ, PCL, AUDIT and DAST–20.
- Automatic scoring and interpretation against Australian military norms, where available.
- Ability to print or email results for client records.
- A privacy lock to ensure professional control of the results.
- Recommended evidence based treatment options for major conditions, with case formulation and treatment planning templates.
- Client handouts, videos and resources.
- Clinical resources for professional development.

The app was developed in consultation with the Australian Defence Force, the Veterans and Veterans Families Counselling Service and the Australian Psychological Society as an electronic supplement to DVA's popular *Mental Health Advice Book*. Feedback on the *Mental Health Advice Book* from practitioners indicates that while it is one of DVA's most sought after resources, it can be difficult to reference in a consultation setting. VHMC^2 was developed to address this concern.

The app allows practitioners to access assessment tools, information resources and client handouts from a tablet device during a consultation. Using the privacy lock feature, professionals can even have a patient complete a psychometric measure in the waiting room to track progress at each consultation.

The Veteran Mental Health Consultation Companion is free and available to download in Australia from the App Store (iOS) and Google Play (Android) by searching 'Veteran Mental Health'. More information about the resources available for mental health practitioners, go to DVA's At Ease Professional website https://at–ease.dva.gov.au/professionals/

Matthew is the Director of Mental Health Policy for DVA and represents the Department on the PMHA.

Stakeholder Round Up

Australian Medical Association

The AMA has been a consistent public voice raising awareness of alcohol-related harms and the need for a comprehensive national response. As doctors, we are often at the frontline in dealing with the physical and mental health effects of drinking. The devastating effects of excess alcohol use are comprehensive, and their prevalence is far reaching. The AMA believes that the solutions must be equally comprehensive and far reaching.

At the end of October, the AMA held a National Alcohol Summit at the Canberra Convention Centre. It was an excellent forum, which showed at its best the leadership role of the AMA on a major public health issue. The speakers were incisive, the discussions robust, and the outcomes a clear call for national leadership to tackle the impact of inappropriate use of alcohol. We heard from families, police, all levels of government, doctors, public health experts, and many more.

You can read more about the Summit and watch presentations at: https://ama.com.au/alcoholsummit

Private Healthcare Australia

Private Healthcare Australia will be running two national conferences back to back at the start of March 2015. The first conference being the Claims Leakage and Fraud Forum in Adelaide, at the Convention Centre on 3 and 4 March 2015. This will be directly followed on by the Private Healthcare Australia Conference at the same venue.

The Claims Leakage and Fraud Forum is open to all stakeholders. This year's Forum theme is e-Fraud and Analytics and will focus on organized crime, online scams, identity fraud and practical detection methods as well as reporting and prosecuting of offenders.

The 2015 Annual Conference, "Private Health Insurance: The Best Care at the Right Price", will be held on March 4, 5 and 6. Key topics which the conference will address include ways in which the Industry can promote Integrated Care to deliver better health outcomes at lower cost; how funds in America utilise Government programs to enhance both their business models and the care they provide; the political environment prevailing at the time; responding to the challenges of a heavily regulated business environment; thought provoking addresses from leading Australian Social Thinkers; and improving health outcomes.

The conferences presents a chance for the Industry to demonstrate to both the Government and the Opposition that Private Healthcare Australia is focused on reducing the amount of fraud and inappropriate billing and also purchasing improved health outcomes for the more than 13 million Australians who have entrusted us to provide their private health insurance.

Registrations are open with early bird deals closing 12 December for the Claims Leakage and Fraud Forum and 3 December for the National Conference. Further information is available from the PHA website at http://www.privatehealthcareaustralia.org.au

Stakeholder Round Up

Australian Private Hospitals Association (APHA)
Mental Health Week Campaign

Since the last edition, nearly 200 private hospitals around the country marked Mental Health Week in October with a campaign that addressed the stigma surrounding mental health head on in a confronting and yet non–threatening way.

We used the slogan, '**The Elephant in the Room**' literally and provided member facilities with an inflatable elephant to sit in their reception areas. Each facility was also provided with an x–frame banner, posters, fact cards, stickers and 100 elephant stress balls. The campaign was an outstanding success taking the Valuing Private Hospitals Facebook page past the 15,000 likes milestone.

Australian Government
Department of Health

The Government confirmed through the 2014–15 Budget:

- $18 million over four years for the Orygen Youth Health Research Centre to establish the National Centre of Excellence in Youth Mental Health;
- $5 million over three years to the Young and Well Cooperative Research Centre to establish a comprehensive new youth e–mental health platform;
- $22 million to maintain Mental Health Nurse Incentive Programme services in 2014–15 at current levels of about 165,000 sessions for approximately 60,000 patients living with severe and persistent mental illness; and
- An additional 10 headspace centres to expand headspace to 100 centres across Australia.

The Government has tasked the National Mental Health Commission (the Commission) to assess the effectiveness of all existing mental health programmes across the government, non–government and private sectors. This process will ensure services are being properly targeted at patients, are not being duplicated, and are not being unnecessarily burdened by red tape. It will also consider existing reporting requirements and the broader data collection issues in mental health.

The Commission's deliberations and its final report, due at the end of November 2014, will inform Government's future decisions on mental health, including funding arrangements. To ensure continuation of service delivery whilst the Government considers the outcomes of the review, existing grants have been extended for 12 months to 30 June 2015.

Private Mental Health Consumer Carer Network (Australia)
(The Network)

Since the last edition, we have appointed Simone Allan as the Network's Coordinator for New South Wales, which brings our full contingent on the Network's National Committee (NC) to the following.

Network Chair	Janne McMahon OAM
Network Deputy Chair	Patrick Hardwick
Network Policy\Governance Officer	Kim Werner
Network Multicultural Adviser	Evan Bichara
Network Coordinator Qld	Norm Wotherspoon
Network Coordinator NSW	Simone Allan
Network Coordinator ACT	Judy Bentley
Network Coordinator Vic	Vacant
Network Coordinator SA	Assoc. Prof. Sharon Lawn
Network Coordinator Western Australia	Patrick Hardwick
Network Coordinator Tasmania	Vacant

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

In November, a specialist position of Multicultural Advisor to the Network was created, which has been taken up by the Victorian Network Coordinator, Evan Bichara. Evan has special expertise in this area. A call for nominations to back fill the Victorian Coordinator position was issued to Victorian Network Members in November. As Chair, Janne McMahon, will continue to facilitate an Advisory Forum for Tasmania until such time as a Network Coordinator can be appointed.

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

Fact Sheet

1. Key Statistics regarding Private Hospital-based Psychiatric Services

	05-06	06-07	07-08	08-09	09-10	10-11	11-12	12-13
Service utilisation and charges								
Persons admitted	21,436	22,510	23,044	24,348	26,673	27,729	29,470	32,025
as a proportion of the Insured Population	0.242%	0.246%	0.242%	0.250%	0.267%	0.270%	0.278%	0.295%
Overnight Inpatient days	417,505				601,275	624,376	673,154	720,849
Sameday admissions	104,391				194,170	169,449	190,311	202,822
Total charges	$222M				$342M			$476M

With respect to charges per episode of Overnight Inpatient Care, in 05-06 the average total charge per episode was $8,650 rising to $10,290 in 09-10. When 09-10 figures are adjusted to 05-06 dollars assuming a constant non-farm GDP inflation of %4, the average total charge per episode in 09-10 is $8,790.

The proportion of the privately insured population in receipt of specialised hospital-based psychiatric services has remained relativley constant over the period covered by the available statitsics. Similarly, after adjustment for CPI increases, the real cost per episode of care has shown only a very slight increase (1.6%).

Payment source (statistics for 2010-2011)								
Health Insurance Funds						90.2%		88.4%
Other payers (DVA, DoD, Workcover, etc.)						9.2%		11.1%
Self-insured						0.6%		0.5%
Demographic profile								
Females	64%	64%	64%	64%	64%	65%	64%	64%
Age (average in years)	46.1	46.3	45.6	45.7	45.8	45.7	45.8	46.0
Older persons (65+)	13%	14%	13%	12%	13%	13%	13%	14%
Diagnostic profile								
Schizophrenia, Schizoaffective and Other Psychotic Disorders	9%	8%	9%	8%	8%	7%	7%	7%
Major Affective and Other Mood Disorders	49%	49%	51%	51%	49%	48%	47%	48%
Post Traumatic and Other Stress-related Disorders	10%	11%	12%	11%	9%	9%	9%	10%
Anxiety Disorders	5%	6%	7%	7%	7%	7%	7%	7%
Alcohol and Other Major Substance Use Disorders	17%	17%	14%	16%	18%	22%	21%	20%
Eating Disorders	3%	3%	3%	3%	3%	3%	3%	3%
Other	7%	6%	4%	4%	6%	4%	4%	5%

The majority of people whose care was paid for by DVA, DoD, Workcover authorities and other third party payers suffered from Post-traumatic stress disorder.

The overall clinical profile of people admitted to private hospital-based psychiatric services, as represented by both the demographic and diagnostic profiles recorded at each episode of care, has remained relatively constant over the period.

The only noticeable change has been an increase in the proportion of episodes where the principal diagnosis was an Alcohol or other substance use disorder. Overall, it is estimated that that diagnosis was identified as a secondary cause of the episode of care in 15% of cases.

Comorbidity	
No major psychiatric comorbidity	75%
with Alcohol or Other Major Substance Use Disorder	15%
with Personality Disorder	12%
with Both	3%

In almost 50% of cases, the current episode of care had been preceded by an earlier admission at some time in the previous 12 months.

With respect to admissions to overnight inpatient care, on average, in 47% of such admissions, the person had had a previous admission to overnight inpatient care at some time in the preceding 12 months.

Self-assessed Clinical profiles and Outcomes for episodes of Overnight inpatient care (MHQ-14 statistics for 2010-2011)

	Mental Health	Social Functioning	Role Functioning
General Population (ABS, 1995)	76	85	83
Overnight Inpatients at Admission	34	27	15
... at Discharge	60	60	60
Change (effect size)	1.28	1.37	1.53

When compared against the general population the average patient, at admission to overnight inpatient care, is in the bottom 5% of the population with respect to their mental health, social functioning and role functioning.

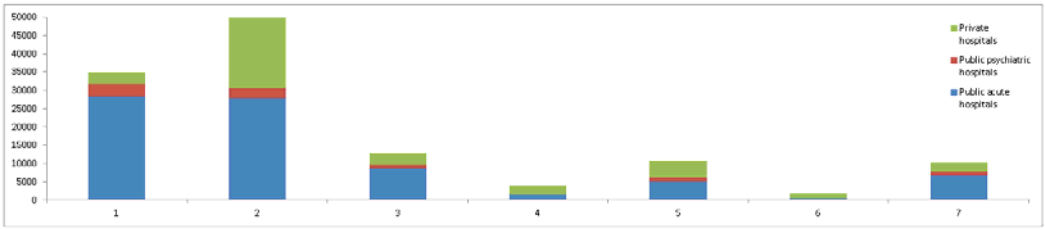
As indicated by both patient self-reports and clinician ratings, the majority of patients have markedly good outcomes, particularly with respect to their capacity to re-engage in their social and other roles.

Clinician-assessed Outcomes for episodes of Overnight inpatient care (HoNOS statistics for 2010-2011)	
Significant improvement	73%
No change	24%
Significant deterioration	3%

2. Comparison of the casemix of Public and Private hospital-based specialised Psychiatric Services

Separations from Overnight Inpatient Care by Sector/Hospital Type in 08-09 (from AIHW)

Separations from Private hospitals account for approximately 28% of ALL separations from specialised psychiatric overnight inpatient care for adults; separations from Public psychiatric hospitals account for a further 8%, whilst separations from Public acute hospitals account for the remaining 64%.



1 - Schizophrenia, Schizoaffective and Other Psychotic Disorders
2 - Major Affective and Other Mood Disorders
3 - Post Traumatic and Other Stress-related Disorders
4 - Anxiety Disorders
5 - Alcohol and Other Major Substance Use Disorders
6 - Eating Disorders
7 - Other

Involuntary admissions by Hospital Type	Public acute hospitals	Public psychiatric hospitals	Private hospitals
	41.3%	62.7%	0.3%

Note: The statistics provided in this second section are for ALL separations from specialised, hospital-based, psychiaric care, regardless of whether those services were publicly funded, payed for by health insurers or other third-party payers, or payed for by the individual person in receipt of care.

PMHA Representatives Contact Details

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