PMHA | PRIVATE MENTAL HEALTH ALLIANCE

NEWSLETTER

10th Edition
December 2011

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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 and Ageing

From the Chair

Philip Plummer

Welcome to the Christmas Edition of our newsletter, which comes at the end of a busy and exciting year for the PMHA and its Centralised Data Management Service (CDMS).

Progress Report 2009–11 Launch

The PMHA has endorsed a progress report covering the period 1 July 2009 to 30 June 2011. A copy of this comprehensive report is being circulated with this Edition. It covers all major PMHA and CDMS activities and those of the Private Mental Health Consumer Carer Network Australia (the Network). The report is a reference for stakeholders and has informed the development of our work plans going forward.

Guidelines 2012 Edition Launch

Our Collaborative Care Models Working Group has finished its work on the 2012 Edition of the *Guidelines for Determining Benefits for Health Insurance Purposes for Private Mental Health Care*. The Guidelines now include advice for services in the private sector that substitute for traditional admitted hospital–based care. These *Alternatives to In Hospital Treatment* guidelines will assist providers, payers, consumers and carers, better understand the nature of these services and the terminology involved. A complimentary copy of the 2012 Edition is being released with this newsletter.

Quality Improvement Project

The PMHA Quality Improvement Project, or QIP as we call it, is progressing well with all four work programs well underway and some nearing completion.

Work Program 1: Consumer Perceptions of Care

The new *PMHA National Model for the Routine Collection, Analysis and Reporting of Consumer Perceptions of Care by Private Hospital–based Psychiatric Services* (CPoC National Model), has been written. It has received favourable review with changes made based on stakeholder advice. The CPoC National Model was presented at the Australian Private Hospital Association's Congress on 17 October in Sydney. We anticpate that private hospitals who wish to start submitting CPoC data will be able to do so early next year.

Work Program 2: Outcomes in Private Psychiatry Practice

Dr Bill Pring from the QIP Steering Committee and our Senior Research Officer, Ellie Rosenfeld, visited each state in late July through to early October to meet with psychiatrists to discuss the establishment of a *Private Psychiatrist Research Network* (PPRN). The first activity of the PPRN is a psychiatrists' online workload survey, to be conducted in March next year. The online Pilot was completed in November. The second activity will then be a peer–reviewed PPRN project about patients with complex needs for care.

Work Program 3: Borderline Personality Disorder (BPD)

A Discussion Paper has been written and is currently being reviewed by the Network and the QIP Steering Committee. Two BPD surveys are planned for next year. The first will be an online survey of psychiatrists and the second will be for hospitals. The methodology for the surveys is yet to be determined.

Work Program 4: Internet Access to the PMHA CDMS

This activity was originally only to involve a scoping exercise to determine the requirements for a model Agreement that would enable appropriate and secure internet–based access for participating stakeholders to the data currently held by the PMHA's CDMS. Additional funding from the Commonwealth, however, enabled the redevelopment of the PMHA website to be completed with the architecture now in place to eventually enable secure access for private hospitals and private health insurers to CDMS Training Resources and Standard Quarterly Reports. Work on the protocols for external user access to the PMHA CDMS database will be underway in the new year.

Mental Health Reform Update

On 19 August 2011, the Council of Australian Governments (COAG) agreed to the development of a *Ten Year Roadmap for National Mental Health Reform* to guide the ongoing reform of the mental health system for Australia. It is anticipated that the Roadmap will be released before the end of this year. It will set out priorities for reform activity to steer governments by providing a framework and guide to targeting future investments in the mental health system.

The Commonwealth has asked the new National Mental Health Commission to monitor and report on the performance of the mental health system and related systems. This will include the ongoing evaluation of the Roadmap. The Commission will be established as an Executive Agency within the Prime Minister's portfolio from 1 January 2012.

The Commission will be based in Sydney and is expected to hold its first meeting early in the next year. Ms Robyn Kruk AM is the CEO–designate with almost 30 years of significant public sector experience, including as Director General of NSW Health and Director General of the NSW Department of Premier and Cabinet.

Psychiatrists' Workload Study 2012

online from March 2012

Dr Bill Pring

In this article, I want to provide some further detail on our Psychiatrists Workload Study (or WLS), which gets underway in March next year, as a core component of the PMHA's Quality Improvement Project (QIP).

Why a Psychiatrists Workload Study?

Psychiatrists are in short supply in Australia (Fletcher and Schofield, 2007), and as a professional group, they are steadily aging. In 1999, one quarter of the Royal Australian and New Zealand College of Psychiatrists (RANZCP) members were aged 55 years and over (Draper, Winfield and Luscombe, 1999). This proportion had increased to almost a third (31%) by 2003.

Though psychiatrists retire later than the Australian general population, an RANZCP workforce survey in 2005 found that 17% of psychiatrists planned to retire in the next five years, with a further third planning to reduce their working hours (Fletcher and Schofield, 2007; MHWAG, 2008). As older psychiatrists retire the shortage of psychiatrists will become more acute (Fletcher and Schofield, 2007). Concomitantly as the Australian population increases, so will the approximately one in five Australians who experience mental illness rise, as a total number of Australians requiring mental health services (AMWAC, 1999, in Fletcher and Schofield, 2007).

The different distribution of psychiatrists between metropolitan and rural areas remains an ongoing concern. People living in rural and remote areas have less than half as much access to psychiatrists as metropolitan Australians. There is difficulty in recruiting psychiatrists to public practice and an increasing reliance on overseas graduates in rural areas (MHWAG, 2008).

Next year is an opportune time to conduct a survey of Australian psychiatrists' workload. Apart from surveys run by Australian Institute of Health and Welfare and the Private Practitioners' Network of the RANZCP, a comprehensive psychiatrists' Workload Survey exploring the nature of patient characteristics in addition to practice characteristics has not been conducted for some time in Australia.

The main issues of our investigation will be the following.

- Psychiatrist (participant) demographics
- Practice characteristics
- Patient demographics
- Patient characteristics: clinical; lifestyle; additional estimates of average numbers of patients seen over defined time-frame
- Other agencies and professionals involved in patient care
- Perception of changes in patient population over time

Current Status

The development of the WLS is well underway, with the QIP Steering Committee having signed off on the methodology in October. The WLS will be as brief and straightforward as possible, with the number of questions kept to a minimum.

The Steering Committee also agreed to a proposal emanating from our state visits and consultations, to access existing psychiatrist data from the *Medical Workforce in Australia: Balancing Employment and Lifestyle (MABEL) Study*, to be used as a cohort for comparison with some WLS characteristics.

WLS Pilot Study 2011

The WLS Pilot Study took place in mid November. The psychiatrists on the PMHA's Private Practice Research Network and the Australian Medical Association (AMA) Psychiatrists' Group participated. The Pilot Survey responses will be exclusively used to further shape the WLS survey proper.

WLS Online 1 March 2012

The WLS will be conducted online starting on 1 March next year and run until the end of the month. To maximise participation, multiple avenues will be used to advertise the WLS, including through the AMA, RANZCP, and the Chief Executive Officers of Private Hospitals.

Advance email notification, invitations and reminders will be issued to all psychiatrists with email addresses. The email invitation will contain the internet link to the online survey protocol and a PDF of the protocol to enable psychiatrists to print out and return the survey by post, if they so wish.

References

Fletcher S and Schofield D (2007), 'The impact of generational change and retirement on psychiatry to 2025' *Biomed Central Health Services Research*, Vol. 7: 141.

Draper B, Winfield S and Luscombe G (1999), The Senior Psychiatrist Survey 1: age and psychiatric practice *ANZJ Psychiatry* 1999: 33: 701-708.

Mental Health Workforce Advisory Committee Mental Health Workforce: Supply of Psychiatrists (2008), cited 1st April 2011.

Bill is a psychiatrist who represents the AMA on the PMHA and is a member of the QIP Steering Committee.

Collaborative Models Working Group

Phillip Taylor

The PMHA *Collaborative Care Models Working Group*, or CCMWG is constituted by the major stakeholder groups that comprise the private mental health sector. Current representatives include:

1.	Phillip Taylor	Chair and Secretary
2.	Bill Pring	AMA
3.	Richard Astil	RANZCP
4.	Carol Turnbull	Australian Private Hospitals Association
5.	Helen Eriksson	Australian Health Insurance Association
6.	Pam Connor	Australian Psychological Society
7.	Kim Ryan	Australian College of Mental Health Nurses
8.	Liz Sommerville	Australian Association of Social Workers
9.	To Be Advised	Australian Association of O/Ts
10.	Janne McMahon	Network (Consumer)
11.	Patrick Hardwick	Network (Carer)
12.	Bradley Schulz	Department of Health and Ageing
13.	Kym Connolly	Department of Veterans' Affairs

We anticipate that the Royal Australian College of General Practitioners will be providing a GP representative for the Working Group in 2012.

Release of National Guidelines for Alternatives to Hospital Treatment

In October, the Working Group completed the development of industry agreed national guidelines for services in the private sector that substitute for traditional admitted hospital–based care for people with a mental illness.

These *Alternatives to In Hospital Treatment* guidelines have been included in the *Guidelines for Determining Benefits for Health Insurance Purposes for Private Mental Health Care 2012 Edition*, as circulated with this Newsletter. Further copies can be obtained from the PMHA website at www.pmha.com.au

2011–13 Work Program

Since its inception in 2008, CCMWG has consistently identified collaboration, communication and coordination as major issues for the private mental health sector. The PMHA discussion paper titled, *Update on Funding Private Mental Health Services: Discussion Paper 2010*, identified that private hospitals, psychiatrists and GPs have critical roles to play in the private sector as the key points of focus for achieving continuity of care, particularly given the difficulties some consumers and carers experience in both accessing and then negotiating, their way through the system.

Anecdotal feedback appears to indicate that while the volume of people now being seen by GPs, psychologists and allied health professionals under Medicare has grown, so have the reports of problems with referral and communication pathways.

CCMWG will now focus its work program on the development of nationally agreed *Best Practice Guidelines for Communication and Collaboration for Private Mental Health Service Providers*. A broad outline for the development of the Guidelines is underway and will include the following.

- Preamble
- Purpose of the Guidelines
- Pathways to care including private and public:
  - Who communicates with whom?
  - What are the problems?
- Case Management
  - Who manages the problems?
  - Who is the final decision maker?
  - Under what circumstances do Case Managers change?
- Best Practice in collaborative care
- Communication methodology
- Communication tools and checklists

The RANZCP Private Practitioner Network (PPN) is interested in pursuing the issue of referrals and communication pathways with CCMWG, so we have invited the PPN Chair, Dr Gary Galambos, to participate at our next meeting.

Phillip is Director of the PMHA and Chair of the CCMWG.

Australian Commission on Quality and Safety in Health Care (ACSQHC)

Dr Nicola Dunbar

The Australian Health Ministers Advisory Council has asked ACSQHC to identify a small number of national safety and quality goals for Australia that could form the basis for concerted and collaborative national action to improve the health system over the next five years. The goals are intended to address issues regarding the prevention of harm, the delivery of appropriate care and achievement of desired outcomes, and the experience of the patient in the health system. At this stage, mental health is not identified as a priority within the draft goals. It is anticipated, that the application of all the goals in mental health settings will be considered as part of further development and implementation processes. A discussion paper with the draft goals has been released for public consultation. The consultation process began in November and will continue until early February 2012. A final set of recommended goals will be available in late March 2012, and these will be submitted to Health Ministers for endorsement. The goals will build on the Australian Safety and Quality Framework for Health Care and the National Safety and Quality Health Service Standards. Further information is available from the ACSQHC website at: www.safetyandquality.gov.au.

National Safety and Quality Framework

The Australian Safety and Quality Framework for Health Care describes a vision for safe and high quality care for all Australians, and sets out the actions needed to achieve this vision. The Framework specifies three core principles for safe and high quality care. These are that care is *consumer centred*, *driven by information*, and *organised for safety*. The Framework was endorsed by Health Ministers in November 2010 and provides 21 areas for action that all people in the health system can take to improve the safety and quality of care provided in all healthcare settings over the next decade. The Framework applies in all parts of the Australian health care system, and can be used by primary, community, and acute health care settings.

Patient Experience Surveys

Another area the Commission is working on is patient experience surveys, which is a key input into measuring the safety and quality of care, and patient centred care. At present, it is not possible to have a national indicator around this because of the variation in the surveys and data collections that currently exists around Australia. The Commission is working with the Mental Health Information Strategy Subcommittee (MHISS) on addressing this and developing a core set of questions that can be used by various jurisdictions. An expert round table will be established in December 2011 to look at this work. The aims of the Roundtable are to:

- share information about current practice in hospital patient experience surveying;
- present some international approaches to patient experience measurement; and
- reflect on lessons learned and next steps.

It is envisioned that the Roundtable will inform the development of a national approach to hospital patient experience measurement. The Director of the PMHA's CDMS, Mr Allen Morris–Yates, has accepted our invitation to participate in the Roundtable.

Project Officer

The Commission has appointed a clinical nurse consultant, Mr Andrew Moors. Andrew has worked in both the public sector and the community and will be assisting with the Commission's work on the national psychiatric medication chart for psychiatric hospitals and on the deteriorating patient.

Recognising and Responding to Clinical Deterioration

The Commission's work on the deteriorating patient essentially aims to improve the recognition of and response to, clinical deterioration in hospitals and other acute care facilities. Initial priorities in this program to support work at a national level include the development of a nationally agreed *consensus statement* regarding the essential elements for recognising and responding to clinical deterioration; an *implementation and action guide* to support the consensus statement and provide information about how the elements within it can be put into practice for all patients across all acute settings; and an *evidence–based adult general observation chart* that incorporates features to support the identification of patients who are deteriorating, and prompt action to properly manage these patients. While this work is currently directed at patients who are physically deteriorating, similar work will be undertaken for psychiatric deterioration after this work is completed.

National Safety and Quality Health Service Standards and Accreditation

Australian Health Ministers endorsed the *National Safety and Quality Health Service Standards* (NSQHS) in September 2011. They are considered essential to improving the safety and quality of care for patients and provide a clear statement about the level of care consumers can expect from health services. The Commission believes that accreditation promotes safe patient care and continuous quality improvement of health service organisations through a process of regular assessment and review. Accreditation against the NSQHS Standards will provide a public marker of safe and good quality care.

An *Australian Health Service Safety and Quality Accreditation Scheme* will build on the strengths of the current accreditation arrangements to promote national coordination of accreditation processes. This will enable improvements to be applied more broadly across health service organisations. Under the new arrangements, health services such as hospitals and day surgeries will be accredited against the NSQHS. Other health services may choose to use the NSQHS Standards as part of their internal quality systems. It is anticipated that full implementation of the NSQHS Standards will commence from 1 January 2013. ACSQHC recently completed an initial mapping exercise of the revised National Standards for Mental Health Services to the NSQHC. The draft is currently being considered by the Commission's accreditation team.

Dr Dunbar is a Program Manager with ACSQHC and attended the October PMHA meeting.

Stakeholder Round Up

Australian Medical Association (AMA)

In 2011, there was some delay in the provision of our AMA Psychiatrists' Newsletter while the Federal AMA evaluated the outcome of the 2010 trial. The trial of the Newsletter proved highly successful and the AMA has agreed to continue to provide three *AMA Psychiatrists' Newsletters* per year to **all** psychiatrists with email addresses throughout Australia. The next Edition will be released before the end of this year and is packed with information to bring psychiatrists up–to–date with the overwhelming range of health reforms that have taken place in 2011. It will include articles on:

- Health Reform
- Mental Health Reform
- AMA Mental Health Position Statement
- RANZCP Private Practitioner Network
- PMHA Quality Improvement Project

Australian Private Hospitals Association (APHA)

The APHA held its 31st Annual National Congress in Sydney from 16 to 18 October 2011. The theme of this year's congress was *Private Hospitals: Evolution through Innovation*. The Congress looked at Safety and Quality, Mental Health, Community Health Innovation, Health Workforce and Communications and Marketing. The sessions dedicated to mental health, included presentations on the Perceptions of Care project, Trans Cranial Magnetic Stimulation and Activity Based Funding in the Private Sector. Congress presentations are available from the APHA website at: http://www.apha.org.au

Private Healthcare Australia

The Australian Health Insurance Association (AHIA) recently changed its name to ***Private Health Australia***. Private Health Australia still represents the Private Health insurance industry and the millions of Australians who have chosen Private Healthcare Cover through our industry health funds. You can find out more at the website: www.privatehealthcareaustralia.org.au

Australian Government

On 2 August 2011, the Commonwealth, State and Territory (the States) governments finalised the National Health Reform Agreement (the Agreement). This Agreement supersedes the *National Health and Hospitals Network Agreement* (April 2010) and the *Heads of Agreement – National Health Reform* (February 2011). The Agreement sets out the financial and governance arrangements for Australian public hospital services, and the governance arrangements for primary health care and aged care. The "pillars" of reform are already known from the previous agreements. The Australian Government has published the following progress report on National Health Reform Agenda, which is available at:

http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/Content/nhr–progress–delivery

Private Mental Health Consumer Carer Network

The Network appeared before Senate Community Affairs Reference Committee Inquiry into Commonwealth Funding and Administration of Mental Health Services on 5 September 2011 at Parliament House in Canberra to give evidence about the negative impact on mental health consumers of both the rationalisation of allied health treatment sessions and, in particular, the rationalisation of GP mental health services. These concerns were also highlighted in the Network's submission to the Inquiry.

The Network recently restructured the previous role of its Deputy Chair into a shared role between two Deputy Co–chairs. The Deputy Co–chairs for the Network for the period 1 July 2011 to 30 June 2013 will be Ms Kim Werner and Mr Patrick Hardwick. The Deputy Co–chair arrangements will be reviewed six months before the end of June 2013.

Fact Sheet

Since our last Edition of the PMHA Newsletter, the Australian Institute of Health and Welfare (AIHW) asked the PMHA's CDMS for statistics on population seen by Hospitals and DoHA asked for statistics on outcomes of care. The CDMS wrote this into a single analysis process and the report titled:

COAG Indicator Statistics for the National Action Plan for Mental Health Indicators 5 and 6 and National Healthcare Agreement Indicator 21 for 2010–2011 Financial Year (FY)

Set out below are the key tables which have been extracted from the Report. The HoNOS referred to in this Fact Sheet is 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. Further details regarding this instrument can be found in the most recent edition of the *CDMS Annual Statistical Report*.

Number of persons receiving care from Private Hospitals with Psychiatric Beds.

Statistics for COAG Annual Report Indicator 5: *Percentage of population receiving clinical mental health care.*

FY ending	June 2007	June 2008	June 2009	June 2010	June 2011
NSW	6,566	7,315	7,709	8,145	8,255
VIC	6,093	6,224	6,355	6,544	5,660
QLD	4,965	4,789	5,266	5,392	5,622
SA					Surpressed
WA	2,168	2,181	2,630	3,047	3,255
TAS					surpressed
ACT					surpressed
Australia	22,520	23,155	24,528	25,536	25,710

Demographic attributes of persons receiving care from Private Hospitals with Psychiatric Beds.

Summary of statistics provided to the AIHW to enable reporting in respect of National Healthcare Agreement Performance Indicator 21: *Treatment rates for mental illness.*

Age distribution of all persons receiving care from Private Hospitals with Psychiatric Beds.

FY ending	June 2007	June 2008	June 2009	June 2010	June 2011
15–19	2.8%	2.3%	2.5%	2.2%	2.3%
20–24	7.4%	7.0%	7.1%	7.2%	7.2%
25–29	6.3%	7.0%	7.3%	7.4%	7.3%
30–34	7.8%	8.2%	8.4%	8.3%	8.6%
35–39	10.7%	10.5%	10.0%	10.9%	10.7
40–44	9.7%	10.0%	10.6%	10.8%	10.6%
45–49	10.7%	10.5%	10.1%	10.4%	10.0%
50–54	10.3%	9.8%	9.8%	9.9%	10.3%
55–59	10.4%	10.0%	9.5%	9.0%	9.2%
60–64	8.8%	9.5%	9.8%	9.1%	8.9%
65–69	4.4%	4.6%	4.8%	5.3%	6.0%
70–74	2.7%	2.9%	2.8%	3.0%	3.2%
75–79	2.7%	2.6%	2.4%	2.1%	2.0%
80–84	2.4%	2.4%	2.4%	2.0%	1.8%
85+	2.0%	2.1%	2.2%	2.0%	1.7%
NR	0.9%	0.5%	0.2%	0.4%	0.2%

Remoteness of the Area of Usual Residence of all persons receiving care from Private Hospitals with Psychiatric Beds.

Remotness	Financial Year ending June 2007	June 2008	June 2009	June 2010	June 2011
0 – Major Cities	84.2%	83.9%	83.4%	83.1%	81.7%
1 – Inner regional	12.4%	12.9%	13.2%	13.5%	14.5%
2 – Outer regional	2.6%	2.5%	2.6%	2.7%	3.0%
3 – Remote	0.4%	0.3%	0.4%	0.4%	0.4%
4 – Very remote	0.1%	0.1%	0.1%	0.1%	0.2%

Relative Socio–economic Disadvantage of the Area of Usual Residence of all persons receiving care from Private Hospitals with Psychiatric Beds.

Relative Disadvanatge of Area of Usual Residence	Financial Year ending June 2007	June 2008	June 2009	June 2010	June 2011
1 Most disadvantaged	9.7%	11.1%	8.4%	7.6%	7.7%
2	10.4%	10.2%	10.6%	11.2%	11.7%
3	14.3%	15.5%	15.9%	16.1%	16.8%
4	23.7%	23.3%	25.4%	23.5%	24.3%
5 Least disadvantaged	41.7%	39.6%	39.4%	41.4%	39.4%

Outcomes of episodes of Overnight Inpatient Care provided in Private Hospitals with Psychiatric Beds.

Statistics for COAG Annual Report Indicator 6: *Mental health outcomes of people who receive treatment from state and territory public services and the private hospital system.*

Statistics for the 2010–2011 Financial Year

	Significant Deterioration	No Change	Significant Improvement
Number of Separations	742	4,830	14,622
Proportion	3.7%	23.9%	72.4%
	Number of separations that met basic inclusion criteria		25,322
	Number of separations with complete data		20,194
	Proportion with complete data:		79.7%

Reporting of outcomes of people discharged from private hospital psychiatric units is based on all separations from those units that occurred within the identified Financial Year, where the length of stay was greater than 3 days. The count of such episodes is given in the second half of the table as the "Number of separations that met basic inclusion criteria".

For each in–scope separation, an outcome score was calculated as the difference between the total HoNOS scores at admission and discharge i.e. Discharge HoNOS total less Admission HoNOS total score. For both the admission and discharge scores, the total HoNOS score was calculated as the sum of all 12 HoNOS items. The "Proportion of episodes with complete data" identifies the proportion of episodes that had HoNOS ratings completed at both Admission and Discharge.

For each separation, the outcome score was then classified as either 'significant improvement', significant deterioration or no change, based on Effect Size. To do that, the Effect Size statistic was calculated for each individual separation as the ratio of the difference between the admission and discharge score to the group standard deviation of the admission score. A medium effect size of 0.5 was used to assign outcome scores to the three outcome categories. Thus individual episodes were classified as either: 'significant improvement' if the Effect Size index was greater than or equal to positive 0.5; 'significant deterioration' if the Effect Size index was less than or equal to negative 0.5; or 'no change' if the index was between –0.5 and 0.5.

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