PMHA | PRIVATE MENTAL HEALTH ALLIANCE

NEWSLETTER

14th Edition
April 2013

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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 first Edition of our newsletter for 2013, which coincides with completion of the substantive work involved in drafting and negotiating our next funding agreement known as the *AMA Agreement for Services 2013–15*. This Agreement will 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 two financial years from 1 July 2013 to 30 June 2015. The Agreement along with its supporting budgets and work plans have been endorsed and we anticipate final stakeholder approval processes will be completed by the end of May.

PMHA Quality Improvement Project (QIP)

Beyond that, we have been working hard to bring our Quality Improvement Project (QIP) to a successful completion. Our QIP Steering Committee met on 7 March 2013 in Canberra to conclude the QIP and smoothly transition remaining tasks into the work program of the CDMS for 2013-15. As our regular readers will know, QIP was constituted by four complementary activities.

1. Development and Implementation of a Patient Experiences of Care Measure

During the course of QIP, this activity evolved into the development of a *PMHA Patient Experiences of Care Measure* (PMHA–PEx) for both overnight inpatient care and ambulatory care. We worked in close collaboration with the Australian Private Hospitals Association's Psychiatry Committee (APHA–PC) and the National Committee of the Private Mental Health Consumer Carer Network Australia to develop a final set of items for the PMHA–PEx, which were then the subject of a Validation Study conducted last year. All the data from the Validation Study has now been collected and our CDMS Director, Allen Morris–Yates, provides an update in this Edition on current work and the implementation of the measure under the CDMS work program.

2. Outcomes in Private Psychiatry Practice

This QIP activity firstly involved the establishment of a Private Psychiatrist Research Network (PPRN) and then a workload survey of psychiatrists who worked any amount of time in private practice. The *Psychiatrists Workload Survey* asked the psychiatrists that participated to describe the full spectrum of the population they served.

A total of 19 psychiatrists joined the PPRN, which included the 10 psychiatrists who comprise the Australian Medical Associations Psychiatrists' Group (AMAPG). After formal endorsement by the AMA and the Royal Australian and New Zealand College of Psychiatrists (RANZCP), the Psychiatrists Workload Survey was pilot tested in November 2011 with members of the PPRN and AMAPG. In March 2012, the final survey was conducted online. The results were analysed and the *PMHA Psychiatrists' Workload Survey 2012 – Final Report* was endorsed and released via the PMHA website in December last year. Two papers for submission to peer reviewed journals have been drafted describing the Survey findings. This formally concludes this QIP activity. Dr Bill Pring will be undertaking discussions with the RANZCP to explore the future role for the PPRN.

3. Borderline Personality Disorder

The objective of the Borderline Personality Disorder (BPD) project was to conduct a survey about the provision of psychological services to people with diagnoses of BPD who are admitted to private hospitals. A draft survey instrument was developed and, after consultation with the APHA–PC, several strategies were used to recruit as many Hospital Managers of private psychiatric hospitals, and Unit Heads of co–located psychiatry units in private hospitals as possible. The survey was conducted online during October 2012, achieving a response rate of 84%. The results were analysed and the *PMHA Provision of Psychological Services for Borderline Personality Disorder in Private Hospital Settings – Final Report 2013* was endorsed and released via the PMHA website in April 2013. This activity is now completed. The Chair of the Network, Janne McMahon, provides further detail in this Edition on this important work.

4. Internet Access to the PMHA's CDMS

At the beginning of QIP, the Commonwealth provided additional funding to enable the architecture for secure internet access for participating private hospitals and private health insurers to the data held by the PMHA's CDMS to be put in place. An agreement titled, *AMA Agreement for Internet Access to the Secure Areas of the Private Mental Health Alliance Centralised Data Management Service Website*, is being completed at present in consultation with the AMA and the PMHA. Both the finalisation of the Agreement and testing of internet-based access for private hospitals and private health insurers will be completed before the end of this year as part of the CDMS Work Plan for 2013–15.

Changes in Staffing and Representation

Our PMHA Research Officer, Ellie Rosenfeld, completes her work for the QIP at the end of April. Ellie goes with our best wishes and deep gratitude for the quality and thoroughness evident in her work on the QIP.

Our longstanding representative for the Commonwealth, Robyn Milthorpe, was recently replaced by Helen Marx. We welcome Helen and thank Robyn for her tireless support for our work in the private mental health sector.

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

PMHA Hospital Manager's Survey of BPD Services

Janne McMahon OAM

In recent years, the debilitating condition of Borderline Personality Disorder (BPD) has been the increasing subject of national and international debate and research over the efficacy of various models of psychological therapy. Australian research with consumers and carers has been conducted about the experience of having a BPD diagnosis, or having a family member with a BPD diagnosis. There has also been "mapping" exercises of services available in the public sector.

The National Health and Medical Research Council (NHMRC) recently published a Clinical Practice Guideline for the Management of Borderline Personality Disorder (NHMRC, 2012). The United Kingdom (UK) National Institute for Health and Clinical Excellence (NICE) published BPD Treatment and Management Guidelines in 2009, and established BPD dedicated services, which have been robustly evaluated. Both the NICE Guidelines and the Australian Clinical Practice Guidelines for BPD Management make Recommendations for the provision of evidence–based psychological services for BPD treatment.

In Australia, the BPD Expert Reference Group (BPD ERG) gathered information from both the public and private sectors on policies and treatment options for people with BPD and their carers.

Considering these burgeoning initiatives, there is a need for comprehensive information about the sorts of treatments provided by Australian private psychiatric services.

Recently the PMHA launched its Final Report on the Provision of Psychological Services for Borderline Personality Disorder in Private Hospital Settings.

International prevalence estimates suggest a range of approximately 0.7%–4.6% of the general population have diagnoses of Borderline Personality Disorder (BPD), [1] with a conservative estimate of at least 2%. In young Australian adults, it is estimated 3.5% have a diagnosis of BPD. [2] These estimates may not seem significant in terms of population prevalence, however, people with this diagnosis constitute a substantial number of patients receiving inpatient and outpatient psychiatric services, making up about 20% of psychiatric inpatients and 10% of outpatients in international surveys [3].

The nature and extent of psychiatric treatment provided by Australian hospitals in the private sector to patients with BPD diagnoses has been unclear. To address this gap in information, we conducted an online survey of Hospital Managers of stand–alone hospitals and Managers of co–located psychiatric units within private general hospitals, who are contributors to the PMHA's Centralised Data Management Service (CDMS), about the psychological services provided to consumers with diagnoses of BPD. The information collected included:

- BPD diagnosis;
- number of people treated for BPD;
- types of psychological treatments used for BPD;
- other health professionals involved in BPD care; and
- the issues clinicians or managers may have encountered in delivering BPD services.

A brief literature search was conducted and, as no comparable instrument for use with Hospital Managers could be found, an original survey was compiled. The advice of the Australian Private Hospitals Association Psychiatry Committee (APHA–PC) was sought regarding effective recruitment strategies. Information was distributed via APHA electronic bulletins and through informal networks of APHA–PC members. The 58 Hospital Managers or Managers of co–located psychiatric units within private general hospitals whose hospitals contribute data to the PMHA Centralised Data Management Service (CDMS) database were emailed an invitation to participate with a link to the SurveyMonkey survey site.

The response rate was outstanding at 84%.

Respondent Characteristics

Of the 49 respondents, most (73.3%) were Hospital Managers of stand–alone private psychiatric hospitals and over a quarter (26.7%) were Managers of co–located psychiatric units within private general hospitals. Given stand–alone hospitals constitute approximately 53% of CDMS data contributors and co–located units make up 47%, this sample was more representative of the BPD services of stand–alone hospitals than of co–located units. As expected with such a high response rate, all Australian states and territories were well represented, though New South Wales, the Australian Capital Territory, and Queensland hospitals were somewhat under–represented, and the remaining states and territories somewhat over–represented. In a small sample of Managers with a very high response rate maintaining confidentiality was essential, hence further information characterising responders from the small number of non–responders was not sought.

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1 Coid J, Yang M, Tyrer P, Roberts A, Ullrich S (2006), British Journal of Psychiatry, 188: 423:431

2 Moran P, Coffey C, Mann A, Carlin J, Patton G (2006), British Journal of Psychiatry, 188: 374–379.

3 Lieb K, Zanarini M, Schmahl C, Linehan M, Bohus M (2004) Borderline personality disorder. Lancet. 2004 Jul 31–Aug 6; 364 (0432): 453–461.

PMHA Hospital Manager's Survey of BPD Services

Janne McMahon OAM

Findings

Hospital Managers recorded a median of 10% of patients treated in the last usual month with a primary diagnosis of BPD, and 15% with a secondary diagnosis. Most hospitals (86.5%) provided group psychological treatment programmes during episodes of overnight inpatient care or episodes of ambulatory care (day patients).

The principal group psychological treatment approach reported during episodes of overnight inpatient care was Cognitive Behaviour Therapy (CBT) (37%), and Dialectical Behaviour Therapy (DBT) for most hospitals (78%) during episodes of ambulatory care (day patients).

The principal individual psychological treatment approach reported during episodes of overnight inpatient care was CBT (48%), with DBT the second most prevalent (22%); and DBT (43%) for ambulatory care (day patients), with CBT the second most prevalent (22%).

The significant issues for clinical staff in the care of patients with diagnoses of BPD identified by Managers were that patients can be challenging to work with; require dedicated, educated, and skilled staff; and a coherent, mutually agreed–on approach.

Most Managers valued staff training for various forms of BPD treatment, though training availability, financial constraints, and obtaining the backing of their management posed challenges. Regarding the use of other agencies and professionals by patients, Managers agreed on the need for cross agency coordination and case management; and felt that private sector patients did not receive adequate public sector services.

Respondents differed in opinion about the therapeutic value of patients' involvement in a range of services; some viewed it positively and others felt involvement with many agencies could be difficult to coordinate and inhibit the development of patient autonomy.

Managers felt that family members and carers of patients with BPD diagnoses could become worn out and more education and assistance for family members regarding BPD management was required. Issues of patient–defined confidentiality regarding information given to family members were the same as for patients with other psychiatric diagnoses. Admissions for patients with BPD diagnoses were considered by Managers to need thoughtful planning for best patient outcomes, and increased community resources were perceived as reducing admission rates.

The theme of the need for broad BPD education for everyone was articulated by the following respondent.

> *BPD is still poorly understood…..we all need far more education from experts in this field, day seminars, and conferences such as the recent one in Adelaide. This should apply to psychiatrists as well, as some of ours openly acknowledge their lack of confidence.*

Conclusions

Survey responses raised complex questions of treatment efficacy based on research evidence, the affordability of providing BPD services, the training and availability of staff, and how BPD services are provided within the broader context of service provision for patients with mental health diagnoses other than BPD. Despite these challenges their approach to the provision of psychological services for their patients was generally in accord with recent NHMRC Recommendations of Clinical Practice Guidelines for BPD Management. The high response rate of this descriptive survey of psychological services, and Managers' practical and informed observations of the parameters of optimal services within their hospitals indicate an ongoing commitment on the part of the Australian private hospital sector to the provision of effective BPD services for their patients.

We believe our survey information makes an important contribution to the broader goal of improving services for patients with BPD diagnoses and their families in Australia. We trust you find the copy of our report being circulated with this Edition useful. Further copies can be obtained from the PMHA website at www.pmha.com.au

All inquiries concerning the Survey should be directed by email to Mr Phillip Taylor at: ptaylor@pmha.com.au

Our thanks go to the Australian Private Hospitals' Association (APHA) who endorsed and promoted this survey, to the APHA Psychiatry Committee and to Ms Lucy Cheetham, APHA Head of Policy and Research for their support and assistance.

Thanks also to members of the Private Mental Health Consumer Carer Network and to members of the PMHA QIP Steering Committee for their invaluable feedback in the early stages of survey development.

Finally our sincere thanks to Ellie Rosenfeld and Allen Morris–Yates for the quality of the analysis of the survey results and thoroughness evident in the preparation of the final report.

Janne was a member of the PMHA's QIP Steering Committee and represents the Private Mental Health Consumer Carer Network (Australia) on the PMHA.

PMHA Patient Experiences of Care Measure

Allen Morris–Yates

Under the PMHA's Quality Improvement Project we have developed a measure of consumer's experience of the care they receive in both the overnight inpatient and the ambulatory care service settings. Last year all private hospitals with psychiatric beds (Hospitals) were invited to participate in the PMHA Patient Experiences of Care (PMHA–PEx) Validation Study. The following Hospitals kindly took part.

1. Mayo Private Hospital, New South Wales (NSW)
2. The Hills Clinic Kellyville, NSW
3. The Melbourne Clinic, Victoria (VIC)
4. Albert Road Clinic, VIC
5. Belmont Private Hospital, Queensland (QLD)
6. Toowong Private Hospital, QLD
7. Currumbin Clinic, QLD
8. Perth Clinic, Western Australia (WA)
9. Sentiens Clinic, WA
10. The Hobart Clinic, Tasmania (TAS)

The Validation Study was conducted between July and September 2012. Now that all the data has been collected from the Validation Study, we are currently completing the statistical analysis of the PMHA–PEx Survey items. In relation to the conduct of the PMHA–PEx Validation Study, analysis has so far shown that the Study protocol was followed and the data was entered in accordance with that protocol. The statistical analysis of the Survey Items for both PMHA–PEx Overnight Inpatient Care Survey and the PMHA–PEx Ambulatory Care Survey will include the following.

Survey Item arrangement factors

Detailed statistical tests to determine the effects, if any, of the following.

- Outcome questions location
- Experience questions order
- Identity request

Performance of each individual Survey Items

Statistical analysis of each individual Survey Item for the following.

- Ease of completion
- Applicability
- Overall sensitivity to Item Arrangement factors
- Sensitivity of individual items to Item Arrangement factors
- Redundancy and content validity
- Predictive validity

Development of Summary Scores

Development of Summary Scores will involve firstly identifying combinations of items by Mapping of questions to theoretical constructs including the National Standards for Mental Health Services and the Principles of Recovery Oriented Mental Health Practice.

Empirically-defined combinations can then be determined using factor analysis of items and sub-sets of items found to relate to key individual items. Selecting the most useful summary scores for inclusion in reports is the next step which requires the following.

- Statistical criteria including reliability analysis, and construct and predictive validity.
- Agreement by stakeholders through APHA–PC and PMHCCN–NC
- Review following use by participating Hospitals

Next steps

Work will now focus on determining the final item content and the framework for analysis and reporting for both the PMHA–PEx Overnight Inpatient Care Survey and the Ambulatory Care Survey for the Australian Private Hospitals Association Psychiatry Committee (APHA–PC) and the National Committee of the Private Mental Health Consumer Carer Network (Australia) (PMHCCN–NC) to review.

After the final form of content and analysis and reporting framework is agreed then the PMHA–PEx Survey instrument together with PMHA–PEx related local analysis and reporting functionality will be integrated within the CDMS Hospital Standardised Measures Database (HSMdb). Implementation by Hospitals then will coincide with the release of the next version of the HSMdb in mid–2013.

Hospitals will be provided with the Survey templates and a manual with suggestions about how to offer the Survey. That manual is being enhanced based on feedback from Hospitals.

All inquiries concerning the PMHA–PEx should now be directed by email to Mr Allen Morris–Yates at: allen.yates@pmha–cdms.com.au

Allen is the Director of the PMHA's CDMS and the QIP Project Manager

Recognising and responding to deterioration in mental state

Dr Leanne Craze

It gives me great pleasure to advise that the Australian Commission on Safety and Quality in Health Care (ACSQHC or Commission) has engaged my company, Craze Lateral Solutions, to prepare a scoping report about recognising and responding to deterioration in a person's mental state in acute health facilities. Joining me in this project are:

- *Douglas Holmes*, a consultant with lived experience of mental illness
- *Eileen McDonald*, a mental health carer/family consultant
- *Private Mental Health Alliance* represented by Phillip Taylor and Allen Morris–Yates
- *St Vincents Hospital's Alcohol, Drug and Mental Health Program (Sydney)*, represented by Dr Peter McGeorge, Steve Bernardi and Douglas Holmes

Report's Purpose

The report's purpose is to inform the Commission about what is known about this topic, gaps that could be addressed by the Commission, and whether and how the Commission's existing framework for recognising and responding to physiological deterioration could be applied to deterioration in a person's mental condition. http://www.safetyandquality.gov.au/our–work/recognition–and–response–to–clinical–deterioration/the–national–consensus–statement/

More information about the ACSQHC's work in mental health can be found at: http://www.safetyandquality.gov.au/our–work/mental–health/

Project Scope

The Project's scope, while recognising that a significant proportion of care for people mental illness is delivered in the community, focuses on people whilst they are being treated in an acute setting, including public and private general and specialist mental health hospitals. The review's scope includes:

- Patients treated in the emergency department, those admitted voluntarily, and involuntary admissions
- All patients, not only those with a mental health admission or in a mental health inpatient facility, but also those whose mental state deteriorates whilst they are in a medical or surgical setting in a general hospital.

The Scoping Review is to focus on key adverse outcomes associated with deterioration in a patient's mental state including those of:

- Suicide
- Self–harm
- Aggression to other patients, visitors and staff
- Self–discharge from acute facilities
- The need for involuntary admission and/or readmission, seclusion and restraint.

Key Questions

With respect to patients who are being treated in an acute setting, including public and private general and specialist mental health hospitals:

1. *How is deterioration in a patient's mental state currently defined and assessed?*
2. *What are the factors, either individual or systemic, that lead to adverse outcomes associated with this deterioration?*
3. *How often are there adverse outcomes associated with deterioration in a patient's mental state? Where are these outcomes currently reported? Are they publicly reported?*
4. *What kind of strategies, tools, frameworks, guidelines and approaches are in place to support early recognition of deterioration in mental state for patients in acute care facilities?*
5. *What kind of strategies, tools, frameworks, guidelines and approaches are in place to manage the potential for adverse outcomes associated with deterioration in a patient's mental state?*
6. *How are these strategies evaluated? How successful have these strategies been?*
7. *What are the gaps that need to be addressed to reduce the risk of adverse outcomes associated with deterioration in a patient's mental state?*
8. *To what extent can the framework developed by the Commission regarding recognising and responding to physiological deterioration be applied to deterioration in a patient's mental state?*
9. *What actions may be needed for the Commission to contribute to improvements in this area?*

Coinciding with the release of this Newsletter, Phillip Taylor and Allen Morris–Yates will be liaising with the Chief Executive Officers of all private hospitals with psychiatric beds via email to advise of arrangements for responding to these questions.

Phillip and I will be liaising with the Executive of the Private Mental Health Consumer Carer Network to welcome input from the Executive and advise of consultation arrangements.

For further information about the Project please contact Leanne:
E: Leanne.Craze@bigpond.com
M: 0408 869 051
T: 02 4625 7777

Leanne is the Director Craze Lateral Solutions, which has been providing a diverse range of quality consultancy services since 1990.

SQPSC | Safety and Quality Partnership Standing Committee

Dr Bill Pring

The Safety and Quality Committee (SQC) was established in March 2002 as a formal subgroup of the National Mental Health Working Group (NMHWG), the forerunner of the Mental Health Standing Committee (MHSC). The role of the SQC was to provide expert technical advice and recommendations to the NMHWG for subsequent decisions on initiatives to address quality and effectiveness requirements of the National Mental Health Strategy. The Safety and Quality Partnership Group (SQPG) was established in March 2003 as a sub–group of the NMHWG to take the safety and quality agenda forward, building on the work of the SQC. In June 2007, the Safety and Quality Partnership Subcommittee (SQPS) became a permanent subgroup of the MHSC following endorsement by the Health Policy Principal Committee (HPPPC), evolving from the SQPG and the SQC. Following a review of the AHMAC Principal Committee structure in late 2011, with recommendations endorsed by AHMAC in early 2012, MHSC became a subcommittee of the newly created Mental Health, Drug and Alcohol Principal Committee (MHDAPC).

Some of the current activity being progressed by the SQPSC is summarised below.

National Standards for Mental Health Services

The Australian Commission on Safety and Quality in Healthcare in consultation with DoHA and SQPSC, has developed a *Consultation Draft Accreditation Workbook for Mental Health* Services. The consultation draft workbook is intended as a tool for health services implementing and being accredited to the *National Safety and Quality Health Service Standards* and the *National Standards for Mental Health Services* and assists in understanding areas of overlap and differences in intent and scope. The consultation draft workbook was made available via the ACSQHC website and the feedback via a survey was invited with the consultation closing on 30 March 2013. A stakeholder workshop is also planned following a review of the survey outcome. The workshop will consider further feedback on the usefulness of the workbook and inform revisions of the final document prior to publishing online.

Seclusion and Restraint Reduction in Mental Health Services

After the completion of the National Beacon Project, states and territories have continued to maintain a focus on seclusion and restraint reduction and support for annual national seclusion and restraint forums. The intention is to continue a collaborative process on an ad hoc basis until more formal annual national data reporting is available.

The key activities for 2013 relate to developing a set of guiding principles on restraint to include the following areas.

- recovery oriented
- consumer focused
- procedural advice to clinicians
- pharmacological guidance
- management of escalating behaviours
- partnership with other key stakeholders such as emergency departments, police
- debriefing for consumer and clinician
- training requirements and workforce development

Reducing Adverse Medication Events (RAME)

The areas of priority for 2013 for the RAME Working Group include the following.

- Safety and quality issues relating to the use of Clozapine.
- Developing national guidelines on physical and metabolic health for mental health clinicians with reference to the use of antipsychotic medication.
- Exploring the development of a national database to record relevant data and information in the areas of deaths and serious adverse medication events in relation to psychotropic medications and associated physical health outcomes.
- A contained literature review to examine critical areas or "hot spot" areas with antidepressant use in the child/youth population.

Electroconvulsive Therapy (ECT)

SQPSC has prepared a summary document for Members which provides responses to four key questions:

(1) Which jurisdictions have ECT guidelines?

(2) What are the protocols around informed consent?

(3) What kind of information is available to consumers regarding ECT? and

(4) What kind of reporting procedures are in place?

The intention is for the SQPSC to move toward the development of a unified national statement regarding ECT.

Bill is a Melbourne–based private psychiatrist who is the AMA representative on the PMHA and represents the PMHA on the SQPSC.

MHISSC | Mental Health Information Strategy Standing Committee

Ms Moira Munro

The Mental Health Information Strategy Standing Committee (MHISSC) provides advice on information and data issues to the new Mental Health, Drug and Alcohol Principal Committee (MHDAPC) of the AHMAC. MHISSC, with varying names, has existed under previous AHMAC committee structures.

It was established in 1991 by the AHMAC National Mental Health Working Group to provide national collaboration in developing and implementing initiatives in mental health information, and to provide expert technical advice and recommendations for the information requirements of the National Mental Health Strategy.

It was originally named the "Mental Health Information Strategy Committee (MHISC). Following a review of AHMAC committees in 2005 the committee was renamed the Mental Health Information Strategy Subcommittee (MHISS).

MHISSC brings together jurisdictional representatives with responsibility for mental health information management and data collection systems, members with technical expertise in mental health data collection and reporting, and key stakeholders including consumers, carers, clinicians, peak bodies and key organisations. MHISSC meets over two days three times a year in order to progress what can only be described as a daunting volume of complex work. Just a few of the issues MHISSC is currently progressing are set out below.

National Mental Health Report – Reporting of Ambulatory Care

Ambulatory Care is not being reported accurately for the Australian private sector in the National Mental Health Report (NMHR). This is of major concern as the NMHR is the primary vehicle for reporting on mental health reform. To address this growing problem, discussions are underway between MHISSC and the Australian Institute of Health and Welfare (AHIW) for the PMHA's CDMS to provide accurate data for the AIHW on Ambulatory Care.

National Repository for Key Performance Indicator (KPI) Data

The National Mental Health Performance Subcommittee of MHISSC is exploring possible national activity to complement current state and territory initiatives to advance benchmarking and use of the KPIs in public mental health services. The following five areas were identified where national collaborative action would serve purposes that complemented the work of states and territories, or filled gaps that could not be addressed by initiatives at the individual jurisdiction level.

1. National leadership development
2. National data repository development for reporting of the KPIs
3. National data standards and indicator development
4. System level information sharing
5. Direct facilitation of benchmarking for selected services

Work is ongoing in relation to (3 and 4) and (2 and 5) are being further developed. The Department of Health and Ageing and the Australian Institute of Health and Welfare have undertaken to progress the concept for developing a data repository for reporting of national benchmarks.

National project – Development of a consumer self–report measure that focuses on the social inclusion aspects of recovery

The Australian Mental Health Outcomes and Classification Network (AMHOCN) was commissioned to develop this consumer self–report measure, which focuses on the social inclusion aspects of recovery. While such a measure is more specific than implied by the recovery concept, its link to recovery is strong. Because people with mental illness often face problems associated with social and economic marginalization, monitoring the extent to which a consumer has positive social inclusion outcomes adds essential information about the individual's overall recovery and complements the clinical outcomes information currently collected.

National project – Measuring Carers' Experiences of Care

This project involves the development of a tool for measuring carers' experiences and perceptions of mental health services within a recovery framework. A literature review found that one measure, the Consumer and Carer Experiences Questionnaires (C&CEQ), may be suitable for further development as a standard measure of carers' experiences of service provision across Australia.

Work is underway to modify the C&CEQ to ensure a consistent response format and suitability for use across all age bands and service settings, cognitive testing of the measure, and scoping of potential field trials. Modifications to the instrument have now been finalised and a penultimate version of the instrument, the Carer Experience of Service Provision Measure (CEoC) will undergo a formal proof of concept trial with a view to reporting the results of this trial to MHISSC in June 2013.

Moira is the Deputy Chair of the PMHA and represents the PMHA on MHISS

Department of Veterans' Affairs and Mental Health

Matthew Jackson

The PMHA recently welcomed the new representative for the Australian Government Department of Veterans' Affairs (DVA), Matthew Jackson. Matthew has kindly provided an overview of DVA involvement in mental health for this Edition.

At the end of 2012, DVA Clients were in round terms as follows.

- 322,000 total beneficiaries
- 150,000 veterans with one or more accepted disabilities
- 46,500 veterans with one or more mental health accepted disabilities

DVA Clients include the following.

- Veterans from a range of operations, including more recently in Iraq and Afghanistan.
- War widows and dependents, including WW1 war widows.

DVA expenditure on mental health for 2010–11 is set out the Table below.

DVA Mental Health Expenditure 2010–11	$M
Pharmaceuticals	34.7
Private Hospitals	33.0
Public Hospitals	30.9
Veterans and Veterans Families Counselling Service (VVCS)	24.1
General Practitioners	19.6
Consultant Psychiatrist	17.7
Mental health budget measures	2.7
Private Psychologists and Social workers	1.8
Australian Centre for Posttraumatic Mental Health (ACPMH)	1.3

DVA purchases across a diverse range of services to accommodate a range of different cohorts.

DVA Mental Health Strategy

DVA has recently completed its consultation on its draft Mental Health Strategy. This strategy builds on an earlier 2001 DVA strategy and provides a framework for DVA's mental health services and programs into the future. It aims to set the context for mental health service system, identify strategic objectives and priority actions, and ensure the best possible outcomes for individual mental health and wellbeing. To date, 30 submissions have been received and there have been over 1,000 hits on the consultation draft website. The next steps include consideration of comments and release of the final Strategy later in 2013.

DVA Programs

At present there are many ways DVA clients can seek mental health support and information. This includes online mental health information and support at the *At Ease Website*, www.at–ease.dva.gov.au, GP services and access to psychological treatment, psychiatric care, and medical and hospital services for those who need it, including post traumatic stress disorder (PTSD) programs.

Counselling and mental health treatment is also available from the Veterans and Veterans Families Counselling Service (VVCS) o 1800 011 046.

DVA has released *PTSD Coach Australia*, a self–help smart phone app designed to help current and former serving personnel understand and manage the symptoms that may occur following exposure to trauma. The app provides education about PTSD, information about self assessment and professional care, and tools to manage the stresses of daily life with PTSD. Clinical notes on how to incorporate the app into health treatment is available on the *At Ease* website www.at–ease.dva.gov.au.

To help serving and ex–serving personnel manage their alcohol consumption, DVA has developed a self–help smart phone application, *On Track with The Right Mix*. Users can track the number and type of drinks consumed; the amount of money spent; and review the impact this has had on their wellbeing and fitness. DVA apps are free and downloadable from both App Store (iOS) and Google Play (Android).

There are also some powerful and moving clips on YouTube of ADF personnel and veterans telling their own story about mental health.

Provider Resources

A series of online training programs has been developed to increase the knowledge and skills of mental health providers who treat veterans and ex–service personnel.

Endorsed by the Royal College of Nursing Australia, *vetAWARE* is an online training program to assist community nurses to better understand the common mental health challenges faced by veterans and war widows and referral pathways. Go to dvatraining.dva.gov.au/register

Understanding the Military Experience is a two hour program to help GPs and mental health providers better understand how military service can impact on the mental health of serving and ex–serving personnel. Go to dvatraining.dva.gov.au/register

Offered through the Australian Medicare Local Alliance, the *Mind the Gap* online training program for GPs is accredited as a Mental Health Skills Training activity and assists GPs manage veteran patients presenting with physical and mental co morbidities. Go to http://amlalliance.com.au/medicare–local–support/mind–the–gap/online–learning

Finally, a new edition of the *Mental Health Advice Book* will be released shortly. This popular resource for providers has been updated to assist health practitioners to deliver the most effective mental health treatments for veterans. Developed in consultation with Australian Centre for Posttraumatic Mental Health, the book is available free from DVA. Go to www.at–ease.dva.gov.au to order.

Matthew is the Director of Mental Health Policy for the Australian Government Department of Veterans' Affairs (DVA)

Stakeholder Round Up (continued)

Australian Medical Association (AMA)

In December 2012, the AMA released the Seventh Edition of its *AMA Psychiatrists' Newsletter* to coincide with the release of the *PMHA Psychiatrists' Workload Survey 2012 – Final Report*. The Newsletter was sent to all psychiatrists throughout Australia with email addresses (over 1400) with a link to the Final Report. Dr Bill Pring, will be presenting some of the findings of the Survey at the Royal Australian and New Zealand College of Psychiatrists Congress in May 2013.

The AMA has also been assisting the PMHA and CDMS Directors with the drafting of the *AMA Agreement for Internet Access to the Secure Areas of the Private Mental Health Alliance Centralised Data Management Service Website*. This collaborative work has involved the following key AMA personnel.

Mr Howard Pickrell	AMA General Manager Corporate Services
Mr John Alati	AMA Senior Industrial and Legal Officer
Mr Michael Manning	AMA Manager Technical Infrastructure

The AMA is currently reviewing the comments from the 8 March 2013 PMHA meeting on the first draft of the Agreement.

Australian Private Hospitals Association (APHA)

The APHA Psychiatric Committee has been engaged in useful discussions with the Australian Commission on Safety and Quality in Healthcare (ACSQHC) regarding the following.

- The relationship between the National Safety and Quality Health Service Standards and the National Standards for Mental Health Services.
- Recognition and Response to Clinical deterioration.
- The ACSQHC's draft Accreditation Workbook Mental Health Services (consultation were completed in March).

Carol Turnbull has accepted nomination as the APHA/PMHA representative Project Advisory Group for implementation of the National Standards for Mental Health Services.

In March, the APHA's 23 Congress in Melbourne included two engaging presentations on mental health issues and young people from Susan McLean, Director, Cyber Safety Solutions and Professor Ian Hickie**,** Executive Director, Brain & Mind Research Institute. Professor Hickie's presentation can be downloaded from the Congress website.

APHA members are gearing up for Private Hospitals Week 12–18 May. Activities include a video competition 'Valuing Private Hospitals – We Do So Much More'. For more information contact Lyndal Bailey at: lyndal.bailey@apha.org.au

Private Healthcare Australia

At the end of 2012, the number of insured persons with hospital cover was 10,710,319 and the number of insured persons with general treatment cover was 12,474,342. A total of 12,486,627 persons held some form of private health insurance. The proportion of the Australian population with hospital cover was 46.9%, with 54.6% of the Australian population having general treatment cover, and overall private health insurance coverage of the Australian population being over half at 54.6%.

In 2010–11, Private Health Insurance paid over $283 million for over 96,000 separations relating to mental diseases and disorders in Private Hospitals and Private Free–Standing Day Surgeries in Australia. In 2010–11, Private Health Insurance paid for more than one–third of all separations relating to mental diseases and disorders in hospitals in Australia.

In terms of Sameday mental health treatment services without electroconvulsive therapy, Private Health Insurance paid over $20 million for 68,640 separations during 2010–11 (88% of total *U60Z Mental Health Treatment, Sameday, W/O ECT* services performed in private hospitals in 2010–11). Overall, Private Health Insurance paid for 68% of total Sameday mental health treatment services without electroconvulsive therapy performed in hospitals in 2010–11.

Stakeholder Round Up (continued)

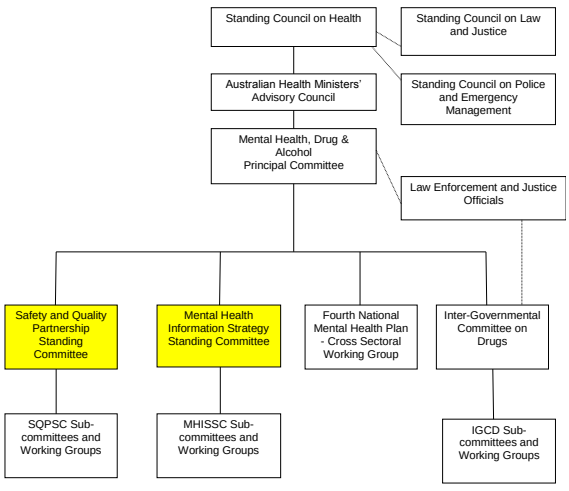
Private Mental Health Consumer Carer Network

Since the last Edition, the Network activities have been largely focussed on the following.

- Network submission to the Royal Commission into Institutional Responses to Child Sexual Abuse.
- Network submission to the Australian Greens (Senator Penny Wright) Rural Mental Health Services Consultation.
- Network submission to the Senate Standing Committee on Community Affairs Inquiry into the National Disability Insurance Scheme Bill 2012.
- Development of online registration for Network Members via the Network Website. You can reach online registration at www.pmhccn.com.au, or by following this link: Join Now!

Australian Government

Following 2012 review of Australian Health Ministers Advisory Council (AHMAC) committee and governance structures the role of the SQPS and MHISS were substantially changed, with SQPSC and MHISSC now being raised to the level of Standing Committees that report directly to the MHDAPC. The PMHA now only has representation on SQPSC and MHISSC. MHDAPC is only comprised of Senior Government Officials. The new relationships are set out in the flow chart below.



COAG Working Group

As outlined in the *Roadmap for National Mental Health Reform 2012–2022* (The Roadmap), COAG agreed to establish a Working Group on National Mental Health Reform (the Working Group) to be the national body that oversees the detailed work required to achieve the aspirations of the Roadmap, and ensure that mental health reform remains a priority across governments.

In the coming months, the Working Group will develop a response to the recent release of the National Mental Health Commission's *National Report Card on Mental Health and Suicide Prevention 2012* (the Report Card) for COAG consideration. By mid–2013, the Working Group plans to provide advice to COAG on the development of a mental health data–sharing protocol and assess the value of national mental health data sets to determine whether information being provided is person centred and whole–of–life.

Then, by the end of 2013, the Working Group will attempt to develop a set of ambitious, but achievable, indicators and targets to demonstrate that mental health reforms are improving peoples' lives. The preliminary set of indicators identified in the Roadmap will be used as a starting point.

Mental Health Statement of Rights and Responsibilities

The revised Mental Health Statement of Rights and Responsibilities (the Statement) was endorsed by Australian Health Ministers in November 2012 and formally launched by The Hon Mark Butler MP, Minister for Mental Health and Ageing, at TheMHS Summer Forum in Sydney on 21 February 2013.

The revised Statement was prepared under the auspices of the Safety and Quality Partnership Subcommittee of the Mental Health Standing Committee of the Standing Council on Health and endorsed by Australian Health Ministers. It is a commitment by all governments to work together to deliver quality mental health services for consumers and carers. It also provides a framework for the promotion of social justice, equity and access within the mental health system.

The Statement can be found at: http://www.health.gov.au/internet/mhsc/publishing.nsf/Content/pub–sqps–rights–toc

PMHA | Centralised Data Management Service

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) has shown that for the 2011–12 Financial Year, there were 28 stand–alone private psychiatric hospitals and 27 psychiatric units located within private general hospitals in operation in Australia.

Together these Hospitals had approximately 2,019 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 52 private Hospitals participating in the CDMS admitted 29,470 patients for psychiatric care. Of those patients, 22,645 had a total of 32,888 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 below and B opposite.

For the 15,883 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 8,322 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.

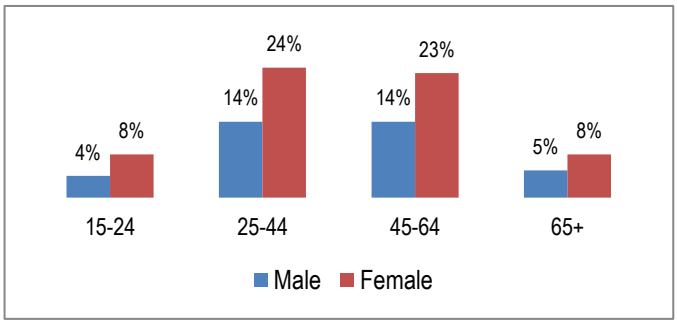


Figure A: Demographic profile (Age group by Sex) of patients admitted to participating private hospitals

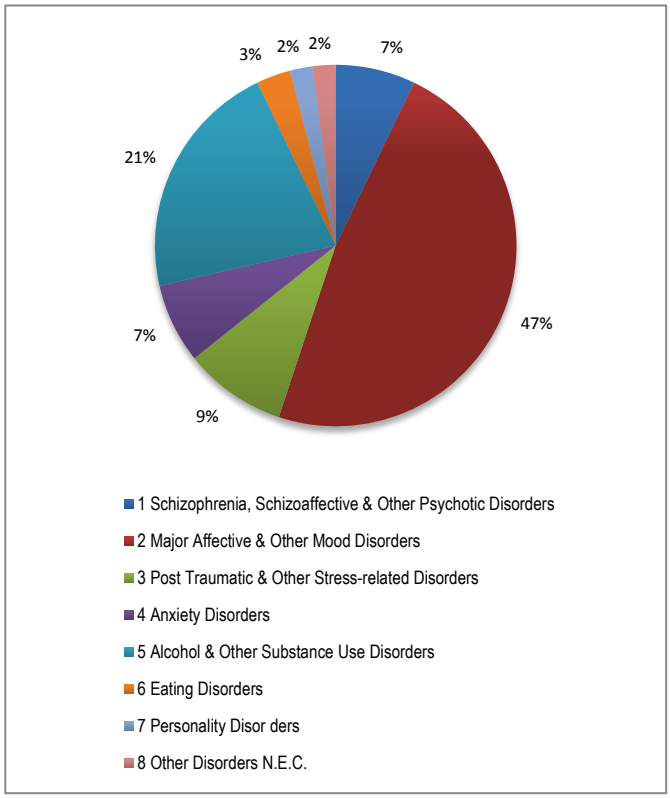


Figure B: Diagnostic profile (proportion in each of the eight major MHDGs) for Episodes of Overnight Inpatient Care during the Financial Year

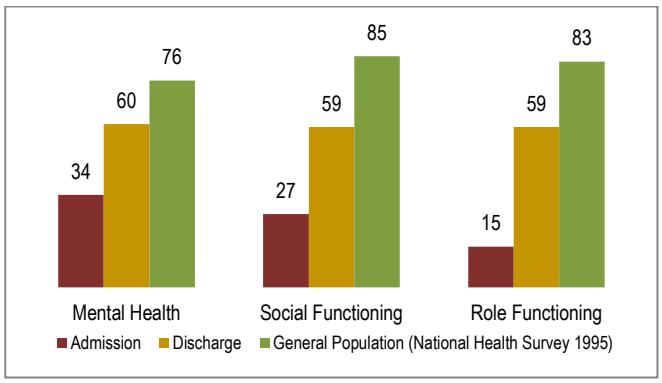


Figure C: Comparison of patients' self–reported clinical status at admission and Discharge with that of the General Population.

Reference

[1] Refer to the *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 2011–12*

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