PMHA PRIVATE MENTAL HEALTH ALLIANCE NEWSLETTER

Sixth Edition August 2010

Australian Medical Association

Australian Private Hospitals Association

Australian Health Insurance Association

Australian Government

Private Mental Health Consumer Carer Network (Australia)

beyondblue – the national depression initiative

▪ FROM THE CHAIR

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The PMHA Newsletter provides a brief summary of some of the issues being progressed by our Private Mental Health Alliance, and its 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.

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.

From the Chair

Philip Plummer

On 3 March 2010, after a consultation period with the health sector and the Australian public on the National Hospital and Health Reform Commission (NHHRC) report, the Australian Government announced the first phase of its health reform package, essentially focusing on the arrangements for the funding and governance of public hospitals.

At the Council of Australian Government (COAG) meeting on 19/20 April, Governments agreed to undertake further work and provide additional funding for mental health service reform, with a report due back for consideration by COAG in 2011.

In the Federal Budget 2010–11, the Government expressed support for the mental health recommendations of the NHHRC, but did not allocate funding for any of these recommendations beyond what the Commonwealth has already committed itself to through COAG.

While many of the reforms and subsequent announcements have been welcomed, there remain deep concerns over whether they will be able to support people with severe and enduring mental health problems, who need community–based care. Their mental illnesses are significant and they often suffer ongoing, or recurrently relapsing, illnesses. They require, but can't access, long–term care. This will require better support and funding for community–based clinical and other support services.

PMHA Quality Improvement Project

Later this year we will commence our Quality Improvement Project (QIP) with the $250,000 of financial support that has now been provided to the Australian Medical Association (AMA) to manage on our behalf.

Our Project is directed at improving outcomes for consumers within the context of the mental health services that are provided by private hospitals and psychiatrists in private practice.

In a brief article in the last Edition, we mentioned that the Project will make better use of the mechanism of the PMHA and its Centralised Data Management Service (CDMS).

Readers of our last Edition will recall that QIP contains a suite of four complementary activities to be undertaken within the context of the available funding.

1. ***Implementation of Consumer Perceptions of Care (CPoC) Measure.*** This first activity involves the implementation of a standardised measure of CPoC in all private hospital–based psychiatric services across Australia.

2. ***Outcomes in Private Psychiatry.*** Work on this second activity will establish a research network of psychiatrists evaluating outcomes within the context of their private psychiatry practice.

3. ***Internet Access to the PMHA's CDMS.*** This third activity involves 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.

4. ***Borderline Personality Disorder (BPD).*** This activity involves preliminary work to scope what models of care are currently being used for people with a diagnosis of BPD.

Work Programs for each of these activities have been developed and are described in much more detail in this Edition. The PMHA has established a small sub–committee to act as a reference group and to assist with steering and managing the Project. The PMHA's QIP Sub–committee is comprised of the following representatives.

Ms Moira Munro (Private Hospitals)
Dr Bill Pring (Private Psychiatrists)
Ms Janne McMahon OAM (Consumers)
Ms Andrea Selleck (Health Insurers)
Professor Andrew Page (Expert Adviser)
Mr Allen Morris–Yates (PMHA–CDMS Director)
Mr Phillip Taylor (PMHA Director)

The PMHA will advertise for a Senior Research Officer (SRO) for the Project in September. The SRO will be employed by the AMA and will be located at the Research Office, Kahlyn Day Centre, in Adelaide. QIP will be underway as soon as the SRO is on board. A copy of the Project Brief is available from the PMHA website at: **www.pmha.com.au/pmha/Publications**

Welcome North West Private Hospital

We recently welcomed North West Private Hospital, which is located in Burnie, Tasmania. North West Private will be participating in the PMHA, our CDMS and the Network. Contact details are available from North West Private's website at: www.northwestprivate.com.au

Philip is the Independent Chair of the PMHA, based in Adelaide.

PMHA–QUALITY IMPROVEMENT PROJECT
Consumer Perceptions of Care (CPoC)

Ms Moira Munro

There is a wealth of evidence available to demonstrate that consumer involvement in the evaluation of mental health services is an essential part of improving the quality of those services for consumers. The information that is derived can help to structure changes not only within the services that are provided, but also in the area of staff attitudes towards consumers and their carers.

CPoC Pilot Study

In 2005, a pilot study was conducted to assess the feasibility and utility of implementing a data collection and reporting process for CPoC that was similar to the existing processes for the collection and reporting of outcome measures under the PMHA's *National Model for the Collection and Analysis of a Minimum Data Set with Outcome Measures* (National Model). Use was made of the Consumer Surveys developed in the United States of America under the auspices of the Mental Health Statistics Improvement Program (MHSIP) and the National Research Institute of the National Association of State Mental Health Program Directors. The MHSIP Consumer Surveys include versions suitable for use in all service settings. The original development process for the Surveys included a high level of consumer and care involvement and consultation. Eight private hospitals with psychiatric beds participated in the pilot. The pilot study showed that the routine collection of a CPoC measure was possible within the private sector. Not only was it possible, but the results indicated that both hospitals and consumers felt the information that was collected was useful and would be used to improve services within these facilities. The Australian Private Hospitals Association (APHA) Psychiatric Committee has given strong support to the establishment of a national system for benchmarking consumers' perceptions of care through a routine data collection and reporting process.

CPoC Work Program

In this part of the QIP Project, CPoC data will be collected from all consumers on discharge from Hospitals participating in the PMHA's CDMS and entered by those Hospitals in the same manner as they currently do for the clinical outcome measures they collect under the National Model. The CDMS Standard Quarterly Reports would then report on the Hospitals' performance benchmarked against the national average.

This is new ground for any health service in Australia and will take considerable time and input to ensure that the collection and reporting process is robust and meaningful. While the full implementation of the CPoC measure will add a much stronger consumer perspective to assist Hospitals quality improvement cycle, it needs to be approached with care, and in three stages.

First, an agreed survey suite needs to be developed. Whilst the two MHSIP surveys used in the CPoC Pilot Study worked very well, both consumers and Hospital managers identified issues that were missed and wording that could be made more appropriate to the Australian context.

Second, given an agreed suite of surveys, hospitals should then be asked to agree on a standard collection protocol. In addition to issues about when the surveys are to be offered, this protocol will need to also recommend mechanisms for ensuring anonymity of respondents. In particular, as it became clear to the CPoC Pilot Study research team that hospital staff were able to identify many consumers by their handwriting and style of written response, written complaint and other comment processes will need to be clearly separated from the CPoC survey administration and collection process.

Third, the CDMS will need to implement the suite of CPoC measures within the existing outcomes measures collection, analysis and reporting framework. That work will entail the specification and implementation of changes to the data submission formats; the data entry, data submission and analysis reporting functions with the HSMdb software now provided by the CDMS to participating hospitals; and, the CDMS data warehouse data processing, analysis and reporting functions.

Deliverables

(1) An agreed survey suite and standard collection protocol.

(2) Implementation of the suite of CPoC measures within the existing outcomes measures collection, analysis and reporting framework.

Moira is the Deputy Chair of the PMHA and CEO of Perth Clinic, an acute private psychiatric hospital in Perth.

PMHA–QUALITY IMPROVEMENT PROJECT
Outcomes in Private Psychiatry

Dr Bill Pring

This part of the PMHA's QIP Project is focussed on better involving psychiatrists in private office–based practice in the data collection and outcome measurement processes of the PMHA and its CDMS. It not only complements the Work Program for the implementation of the CPoC measure detailed above, but would also establish an ongoing Research Network of psychiatrists interested in using outcome measures within the context of their practice.

Work Program – Phase One

The Research Network will be established in Phase One and will involve a survey to define the full spectrum of the population currently served by the private psychiatrist sector. It will also provide a reference against which the clinical needs, patterns of service utilisation, and outcomes of the sub–set of patients seen by private hospital–based psychiatric services, can be compared and contrasted.

Importantly, this research will also provide insight into the combinations of providers who are now working with patients receiving specialist psychiatric care in the private sector.

Deliverable Phase One

A report on the survey of private psychiatrists' caseload suitable for publication in a peer review journal.

Work Program – Phase Two

Phase Two directly involves the Research Network using a peer review approach, to examine the issues encountered in the treatment of patient groups with complex needs for care.

Those patients studied within the peer review process will not be personally identified to the Research Network members. The conclusions of the members will be tabulated by the diagnostic complexity of the patients and the treatments provided.

In addition, this Phase will be supported by the PMHA's CDMS through the provision of aggregate statistics regarding the pattern of service utilisation and outcomes for the patient groups identified by the Research Network.

Deliverable Phase Two

A final report that answers the following questions.

- How do we identify patients with complex needs?
-
- What clinical paths should they follow?
- What issues are likely to be encountered in the treatment of those patients groups?
- Recommendations regarding indicators of outcomes for those patient groups.

Work Program – Phase Three

The third component is a longitudinal study, which would commence after the QIP Project had ended and last for approximately one year. Phase Three would be geared towards the active continuation of the Research Network, building on significant expertise gained during the Work Program.

Phase three would provide a much more detailed longitudinal picture of the diagnoses, care provided, and healthcare community working around the patients needs over the course of at least one year. Such an in–depth view of patients' treatment would provide another very useful piece of information for all the PMHA's stakeholders.

The final component of Phase Three, concerns the feedback about outcome measurement data to the patients. It is intended that, with this small longer term follow–up group, outcome measurement data would be collected in all cases. This may provide an interesting comparison sub–group within the overall study for there to be feedback of the outcome measurement information to the patient, in half the cases involved. Incorporation of this sub–stratification would allow some comparison of quantitative data between a group of people that are given outcome measurement feedback, and a group that are not. It would be intended that the feedback would be obtained from both the treating psychiatrist, and the consumer.

Deliverable for Phase Three

A study protocol for Phase 3 developed in consultation with the Research Network.

Bill is a private psychiatrist in Melbourne and represents the AMA on the PMHA.

PMHA–QUALITY IMPROVEMENT PROJECT
Internet–based Access to PMHA's CDMS

Mr Allen Morris–Yates

Many of our readers will be aware that under the PMHA's *National Model for the Collection and Analysis of a Minimum Data Set with Outcome Measures* (National Model) the PMHA's Centralised Data Management Service (CDMS) provides private hospitals and health insurers with Standard Quarterly Reports regarding the quality, effectiveness and efficiency of private hospital–based psychiatric services.

The content of the current Standard Quarterly Reports provided to Hospitals and Payers by the PMHA's CDMS is severely constrained by their publication format. The recently initiated provision of extracts of the statistical information in an XML format can enable interested users to interrogate the statistics in new ways. Nevertheless, however useful the extracts may be, they are still a relatively limited subset of the clinically oriented information that could be derived from the data held by the CDMS.

Provision of an internet–based interface to the aggregate statistics held by the CDMS, similar to the Clinical Review functions already made available to Hospitals within the HSMdb software, would provide CDMS participants with a substantially more flexible and timely method of obtaining a greatly enhanced array of information.

Access to the CDMS data for clinical research purposes could also be provided through such an internet–based analysis system. At present, using the HSMdb software's clinical review functions, Hospitals do already have access to a very flexible system for investigating their own data. Development of an internet–based system could provide a similar highly flexible mechanism for gaining access to aggregate statistical information based on all CDMS data.

The development of such a system would have immediate benefits for the CDMS's principal stakeholders and could also greatly enhance the capacity of the CDMS data to be used for clinical purposes to improve patient care.

Work Program

This part of the QIP Project is a first step toward enabling internet–based access to be properly undertaken.

The Work Program will involve a scoping exercise directed toward clearly specifying the requirements for a model Agreement that can address the following for stakeholders.

1. Privacy and confidentiality protocols consistent with the National Model's information access guidelines.

2. Protocols for the protection of intellectual property (principally that of the Hospitals that contribute the data) and the publication of information derived from the CDMS.

3. Reliable and cost–effective systems for granting and revoking authenticated user access.

As the information is owned by participating private Hospitals, their requirements with respect to these issues must be clearly identified and addressed.

Deliverables

(1) Specifications of what is required for a model Agreement for internet based access to the PMHA's CDMS that addresses the following for PMHA stakeholders.

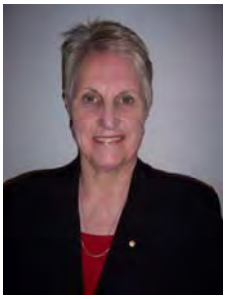
- Privacy and confidentiality protocols consistent with the National Model's information access guidelines.
- Protocols for the protection of intellectual property and the publication of information derived from the CDMS.
- Reliable and cost–effective systems for granting and revoking authenticated user access.

(2) A model Agreement for internet–based access that each organisation whose staff are granted access will be required to sign.

Allen is the Director of the PMHA's Centralised Data Management Service.

PMHA–QUALITY IMPROVEMENT PROJECT
Borderline Personality Disorder

Ms Janne McMahon OAM



Currently, treatment options for people with Borderline Personality Disorder (BPD) vary between services and between the public and private mental health sectors. I think it fair to say, that the private sector does well in treating and caring for people with a BPD diagnosis. Private psychiatrists provide much needed treatment and care, and increasingly private hospitals are offering different types of programs. Allied health professionals are also being engaged to assist in a number of ways.

Within the public sector meanwhile, many consumers and carers feel people in the main are being excluded from mental health care because of practices and misconceptions associated with a particular diagnosis. There has been consistent lobbying for the last 18 months to have the treatment and care for people with BPD better recognised, resourced and coordinated.

The Senate Community Affairs Report of September, 2008 made a Recommendation to establish a national initiative, which would be overseen by a Taskforce to include amongst other things;

- the establishment of designated BPD outpatient care units in selected trial sites in every jurisdiction to provide assessment, therapy, teaching, research and clinical supervision; and
- training program for mental health services and community–based organisations in the effective care of people with BPD.

Consumers and carers continue to lobby for the urgent allocation of new funding for these specialist services dedicated to people with BPD in each state for this very poorly represented group of consumers. They are also calling for services, which will provide assistance to carers.

Work Program

As mentioned previously, the private sector is undertaking treatment for people with the BPD diagnosis in a number of ways. Under the QIP Project, the Work Program for this activity would take the form of a scoping exercise to determine what models of care are currently being used for people with a BPD in private sector settings.

Some aspects of this scoping exercise would be able to be undertaken as part of the other aspects of the QIP Project described above. In the program of work required for the Outcome Measure in Private Psychiatry (outlined in this Edition in Bill Pring's article), for example, questions could be included to elicit information on the following.

- Diagnosis of BPD
- Number of people being treated for BPD
- Types of treatments being used for BPD
- What other health professionals are involved in the care of people with BPD

Private hospital–based psychiatric services could also be asked to provide similar information on what they are able to offer and any difficulties they may have encountered.

This information could then be further developed into a guide for consumers on what to currently expect at each stage of the clinical care pathway.

The findings from this scoping exercise would also help to determine what might be required for the more in–depth work that would be necessary to establish a consistent approach for treatment. It is important to highlight and acknowledge the activities and important role of the private sector. It is believed that this part of our Quality Improvement Project will provide crucial information.

Deliverable

A Report on current practice and what to expect at each stage of the clinical care pathway for BPD.

Janne is the Consumer Representative on the PMHA and the Independent Chair of the Private Mental Health Consumer Carer Network (Australia)

Update of the Hospital's Standardised Measures database (HSMdb) for Participating Hospitals

Mr Allen Morris–Yates

In July 2010, a revised version of the Hospitals Standardised Measures database application, ***HSMdb version 1-80***, was distributed to Hospitals participating in the PMHA's *National Model for the Collection and Analysis of a Minimum Data Set with Outcome Measures* (National Model).

The release of this version has been delayed due to the emergence of problems associated with increased complexity in the coding of outreach care. This meant that significant additional time had to be devoted to the development and testing of this next release.

These problems first became apparent in December 2009 and early January 2010, when the CDMS Director fielded many requests for assistance with the submission of data. During the course of those discussions he was alerted to the fact that several large hospitals that provide very high volumes of outreach care changed their Hospital Casemix Protocol (HCP) Extract practices in 2008 to more closely conform with changes in health insurers and the Australian Government Department of Health and Ageing's requirements.

In the past, the CDMS dealt with the few problematic outreach records by excluding them from subsequent analyses. However, the steady increase in the provision of hospital–in–the–home and outreach care now means that that strategy is no longer adequate. Accordingly, the CDMS has now implemented a complex series of hospital–specific steps to the data processing completed prior to the analyses undertaken in the preparation of the standard quarterly reports. If such a solution had not been implemented the service utilisation statistics for both overnight and ambulatory care would have quite soon become noticeably inaccurate. These same changes have now been implemented within the functions that HSMdb uses to import HCP data for local use by hospitals.

This update of the HSMdb software has addressed those and several other issues in relation to the HCP as follows.

- Enable import and submission of HCP version 0800.
- Add new HCP Identifiers to standard list and update Insurer Names of some existing Identifiers.
- Split processed HCP records into a separate table from the source records to enable more detailed corrections to be made to the HCP data used within HSMdb, and also reduce the volume of data within the table routinely used by HSMdb. Implementation of the following four requirements relating to HCP records processing were dependent on this change.
- Improve identification of the imputed Service Setting for Overnight for Sameday procedures.
- Address variations in the coding of Outreach Care (as discussed above).
- Improve usability of the HCP linkage check report.
- Improve the performance of the HCP import and link and Episode link procedures.

Further information or assistance with the use of HSMdb

In my role as the PMHA–CDMS Director, I am always ready to assist with answers to questions regarding the use of this new version of HSMdb, any aspect of the implementation of the National Model, or the interpretation and use of the Standard Quarterly Reports provided to participating Hospitals and Health Insurers by the CDMS.

My contact details are as follows:

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Telephone: 08 8278 5811
Mobile phone: 0417 268 386

Allen is the Director of the PMHA's Centralised Data Management Service.

beyondblue: the national depression initiative

Ms Leonie Young

beyondblue: the national depression initiative is now in its tenth year working to raise community awareness of depression/anxiety and related disorders and to reduce the associated stigma. A continuing priority from our inception in October 2000, has been a focus on people with the lived experience of depression, consumers and carers. *beyondblue* works with governments, health professionals, research agencies, corporate and community groups, consumers and carers across Australia to address these issues and has been a sponsor of the Private Mental Health Alliance since 2002.

beyondblue/NHMRC Clinical Practice Guidelines

This year, *beyondblue* has developed two sets of draft Clinical Practice Guidelines – for the treatment of depression and related disorders in a) adolescents and young adults, and b) pregnant women and new mothers. These draft guidelines, developed in association with the National Health and Medical Research Council (NHMRC), reviewed the latest international research to identify the best ways to treat and manage depression, anxiety and related disorders.

The guidelines were drafted by expert advisory groups in consultation with health professionals, people with the experience of depression and their carers.

A two–month public consultation period was undertaken and submissions were invited from interested organisations and individuals. During this time, *beyondblue* held a series of public seminars around Australia to talk about and explain the content of the guidelines and invite feedback.

The relevance and importance for clinical practice guidelines are well known and overdue in these fields. There was an absence of any clinical practice guidelines in Australia for the detection and treatment of depression in pregnant women and new mothers. The guidelines for the treatment of depression in young people were out of date and rescinded in 2004 by the NHMRC.

Currently, both guidelines are being redrafted to incorporate feedback from submissions and the public seminars. When completed, the final documents will be submitted to the NHMRC for approval.

Depression in older people

beyondblue has funded a recent study by the National Ageing Research Institute (NARI), ***Depression in Older Age: A scoping study.*** This study aimed to identify gaps in knowledge about the diagnosis and treatment of depression and anxiety among older people.

A primary component of the study was a review of published literature about depression in older people. This review found that certain groups of older people are more at risk of depression and anxiety, including those living in residential aged–care facilities or those in hospital.

Whilst the precise rates of depression and anxiety in older people are unclear, data shows that between 10 and 15 per cent of older people experience depression and approximately 10 per cent experience anxiety. However, the rates of depression among people living in residential aged–care facilities are believed to be considerably higher, ranging from 34 to 45 per cent. Moreover, many of the older people experiencing depression within an aged–care setting may not be receiving the necessary mental health care and treatment.

Recommendations from the NARI study suggest professional carers working in aged care settings need appropriate training in depression awareness, diagnosis and care. The findings also recommend that *beyondblue* makes older age depression and anxiety a priority for research funding and focus on a national awareness campaign to improve mental health literacy amongst older people, their carers and health providers.

Looking after doctors' mental health

Building a society that understands and responds to the personal and social impact of depression, works actively to prevent it and improves the quality of life for everyone affected also requires a focus on the mental health of doctors. The ***beyondblue*** **National Doctors' Mental Health Program (bbDMHP)** aims to:

- address the prevalence of depression and anxiety in doctors
- raise awareness of depression and anxiety symptoms, and encourage help–seeking
- develop self–help tools specific to the medical profession
- develop structured education program for doctors.

To inform the development, implementation and evaluation of this program in association with the Australian Medical Association, Royal Australian College of General Practitioners, Royal Australian and New Zealand College of Psychiatrists, Australian Medical Students' Association and Australian General

Practice Network, *beyondblue* has established an Advisory Committee chaired by Dr Mukesh Haikerwal.

Terms of Reference for the Committee have been finalised, as has a systematic literature review on doctors' mental health. The work of the Advisory Committee will be complemented by a larger Expert Reference Group with broad representation across the medical and mental health sectors.

Progress in this field occurred late last year when members of *beyondblue* met with a representative group of private psychiatrists. This discussion aimed to find ways to improve psychiatrists' profiles in the assessment, diagnosis and management of depression and to address perceived stigma surrounding psychiatrists roles.

Several key actions were identified during the meeting including the promotion of collaborative partnerships between private and public psychiatrists and general practitioners, and the dissemination of more information from *beyondblue* about effective treatments for severe depression and pathways to care.

beyondblue supports MJA supplements

beyondblue has supported eight Medical Journal of Australia (MJA) supplements since 2000 including Depression and Cancer with two more planned for 2010 /2011.

The latest supplement was published in April 2009. This 57–page research supplement – **Depression and Anxiety with Physical Illness** – sheds light on the complex relationship between chronic illness and poor mental health and included 11 research articles and commentary from some of Australia's leading mental health experts.

Previous supplements include **Depression and Primary Care – Expanding the evidence base for diagnosis and treatment**. This 2008 supplement featured new research studies which looked at how depression is treated in a range of primary care settings.

It's important for *beyondblue* to promote the findings to influence best practice – so that people who experience depression and anxiety can receive effective, evidence–based treatments.

beyondblue directory of e–mental health

A directory of e–mental health services and therapies has recently been launched on *beyondblue* website. The directory provides a listing of all known e–mental health services currently available in Australia. E–mental health services are self–help internet–based programs and these services and practices are emerging as a cost–effective and efficacious way of meeting the large unmet need for treatment – yet many people are unaware they exist. The directory aims to benefit the large number of people who need help for depression and anxiety but who are not currently receiving it. This directory lists 37 separate services. Each has a description of the program, the conditions covered, how to access it, who developed it and whether it has been evaluated. To find out more visit www.beyondblue.org.au/ementalhealthdirectory

Free new information resources

beyondblue continues to produce quality materials for the general public and people in the health profession – including a detailed booklet on *What works for Anxiety Disorders*. A full list of all of our materials is available from our website www.beyondblue.org.au

Recent materials

- *A Guide to What Works for Depression* (64–page booklet)
- *A Guide to What Works for Anxiety Disorders* (64–page booklet)
- Fact sheet 44 – Benzodiazepines (traquillisers and sleeping pills)
- Fact sheet – Indigenous Mental Health First Aid Guidelines: Problem Drug Use
- Fact sheet 45 – Problem gambling and depression
- *A Guide to What Works for Depression in Young People* (52–page booklet)

Beyondblue is an independent, not for profit organisation working to address issues associated with depression, anxiety and related disorders in Australia. Although much has been achieved in this area, important work remains to be done. During our third term, to 2015, *beyondblue* will continue to develop and disseminate preventative programs to individuals and the Australian community, while increasing community awareness of mental health issues and addressing the associated stigma.

We aim to deliver the best possible and most up to date information about signs, symptoms and treatments for all Australians living with depression, anxiety and related disorders – and their friends, families and carers

Through continuing to work on existing programs and new initiatives in *beyondblue's* third term (2010 – 2015), and by continuing partnerships with key organisations (including PHMA) we stand by our mission to reduce the prevalence of depression and related disorders and to improve the life of those who are affected by these conditions.

Leonie is the CEO of beyondblue: the national depression initiative

Stakeholder Round–Up

This section of *Our Newsletter* provides a brief snapshot on some of our stakeholders recent activities.

Australian Medical Association (AMA)

The AMA has written to the Prime Minister to support the broader calls for more investment and reform in mental health and better government support and funding for community–based clinical and other support services. In addition, the AMA has included a specific call for improved access to care from specialist psychiatrists in community–based settings.

Private Mental Health Consumer Carer Network (Australia)

DoHA provided funding for the Network to undertake this six month project to:

- draft good practice policy regarding nationally consistent identification policies and good practice protocols; and
- draft generic wording for printed information booklet to be provided to carers of people with a mental illness.

The Project concluded on 31 May 2010 and its final report titled, *Carers Identified?*, is under consideration by the PMHA and several national Government committees. The Project has highlighted the crucial role that GPs play in the identification and support of all carers, including those that care for people with a mental illness. DoHA has provided some additional project funding for the Network to engage with the Royal Australian College of General Practitioners to look at how carers could be better involved in the general practice setting.

Australian Private Hospitals Association (APHA)

The APHA Psychiatric Committee has met twice since the beginning of the year. One of the key issues under discussion has been the changes that many health insurers have made to the level of psychiatric cover in their policy offerings. Fewer than half of the policies available from the major insurers cover the cost of admission to a private psychiatric hospital. Many policies, described as "restricted", limit cover for admission to a private hospital. Although health insurers state on their websites and in written material what services are subject to restrictions, hospitals have reported that many consumers are not aware of what they are covered for, particularly if their cover has changed.

In order to ensure that consumers and their treating psychiatrists are better informed, APHA has produced a brochure, *Admissions to private psychiatric hospitals*, which explains what patients should do to check their level of cover, and reinforces that the minimum waiting time for psychiatric cover within a private hospital is two months, including for pre–existing conditions. The brochure has been distributed to private psychiatric hospitals for passing on to patients and doctors. Copies of the brochure are available from APHA on request.

Australian Health Insurance Association (AHIA)

AHIA recently welcomed figures released by PHIAC, which show an increase in the number of privately insured Australians for the March 2010 quarter. The increase of 0.7% in either hospital, general or hospital and general treatment combined cover membership was good news and will ease pressure on the public health sector. Although, growth rates have decreased in the last 12 months, historically they are better than in 2005/06.

Prior to the introduction to the Medicare Levy Surcharge (MLS) threshold, PHI hospital cover membership growth peaked at 4.5% in the 12 months ending March 2008. Following the Government's changes to the MLS, annual growth in PHI hospital cover membership has been on a steady decline, with latest figures showing growth of 2.2% in the year ending 31 March 2010. If membership had continued at the rate it was growing prior to the MLS threshold changes.

The number of Australians with either hospital, general or hospital and general treatment combined cover increased in the quarter ending March 2010 to 11.5 million. This represented 51.5% of Australians, a 0.1 percentage point increase from the December 2009 quarter.

Australian Government

The Medical Benefits Division of the Department of Health and Ageing's Private Health Insurance Branch recently promulgated the 2010 Edition of the *Guidelines for Determining Benefits for Health Insurance Benefits Purposes for Private Mental Health Care 2010*, for the PMHA under cover of its circular PHI 44/10. These Guidelines have been endorsed by the PMHA and were developed by its Collaborative Care Models Working Group. They include advice that is applicable, in some instances, to both the hospital–based and office–based settings. Copies of the Guidelines can be obtained from the PMHA website at: www.pmha.com.au/pmha/Publications

Fact Sheet

In this Edition's Fact Sheet, we use only a very small amount of the wealth of information that is publicly available in latest *Annual Statistical Report* (ASR 2008–09) from the PMHA's Centralised Data Management Service (CDMS). This latest ASR, reports on services provided by participating private hospitals with psychiatric beds and private psychiatric day hospitals, for Financial Year 2008–09.

ASR 2008–09 includes an Executive summary, and an introduction and overview of the *National Model for the Collection and Analysis of a Minimum Data Set with Outcome Measures for Private, Hospital–based Psychiatric Services* (National Model). The remainder of the ASR is divided into four sections that provide statistical information on the following.

1. Private Hospitals with Psychiatric Beds
2. Indices of data completeness
3. Provision of Hospital–based Care
4. Overnight Inpatient Care

Our website now contains the ASRs for Financial Years 2008–09, 2007–08, and 2006–07. http://www.pmha.com.au/cdms/documents

In ASR 2008–09, under the section on Private Hospitals with Psychiatric Beds, all Private Hospital–based Psychiatric Services that were known to be in operation during that Financial Year are listed. For each Hospital the class of facility (stand–alone psychiatric hospital or psychiatric unit located within a general private hospital) and its location is identified.

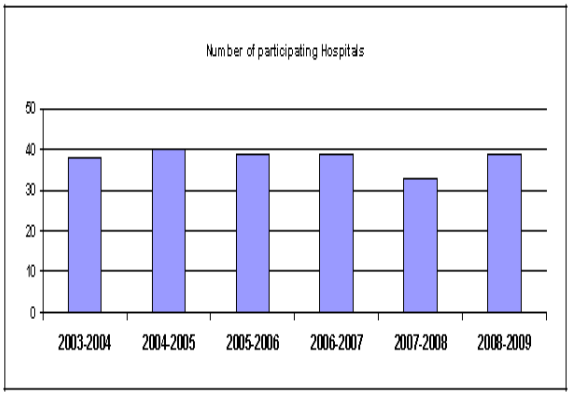
Table 1 below is reprinted from that section and identifies the number of open private hospital–based psychiatric services, the number that were enrolled in the CDMS, and the number of Hospitals that submitted their data to the CDMS during all or part of the Financial Year.

Table 1 The number of Hospitals with psychiatric beds, number enrolled in the CDMS and the numbers actively participating by submitting their data to the CDMS during the financial year.

Number of Private Hospitals with Psychiatric Beds and Private Psychiatric Day Hospitals that were open during the identified Financial Year	52
Number of open hospitals that were enrolled in the CDMS during the year.	47
Number of enrolled hospitals that actively participated in the CDMS throughout the whole year	31
Number that only began their active participation during the year (their data for the year may be incomplete)	9

Figure 1 below provides a historical perspective on the number of actively participating hospitals during the preceding few years.

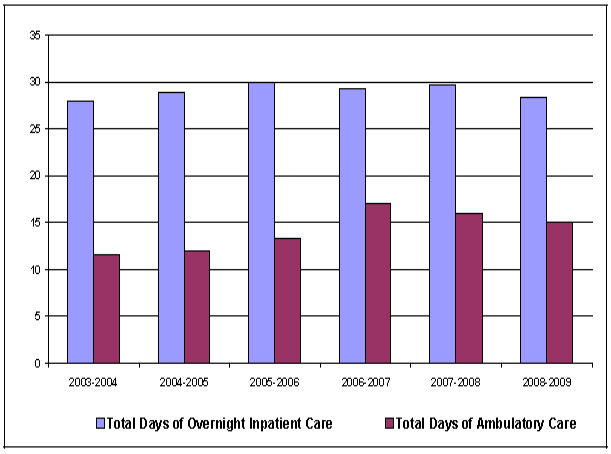
Figure 1 Historical trend in active participation by private hospitals in the services provided by the PMHA's CDMS.



From 1 July 2010, all private facilities with psychiatric beds were participating in the PMHA and its CDMS. Our most recent addition was North West Private Hospital located at 21 Brickport Road in Burnie, Tasmania.

The third section of the ASR 2008–09 provides summary information about the provision of hospital–based psychiatric services. Figure 4 below has been reprinted from that section and illustrates the historical trend in the two key indicator statistics – Average Total Days of Overnight Inpatient Care per Patient and Average Total Days of Ambulatory Care per Patient, during the preceding four years.

Figure 4: Historical trends in the average number of Total Days of Care per Patient within the Overnight Inpatient Care and Ambulatory Care service settings during the identified Financial Years.



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